ADAPTATION OF CHILD PARENT RELATIONSHIP THERAPY FOR PARENTS OF CHILDREN WITH CLINICAL LEVELS OF BEHAVIOURAL PROBLEMS

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Glossary

Types of Therapy

CBPT	Cognitive-Behavioural Play Therapy
BPT	Behavioural Parent Training
CCPT	Child-Centred Play Therapy
CPRT	Child Parent Relationship Therapy
CMT	Child Management Training
CT	Cognitive Therapy
FT	Filial Therapy
GGFT	Guerney's Group-Based Filial Therapy
IPT	Individual Play Therapy
IY	Incredible Years
IY-PT	Incredible Years-Parent Trainig
LFT	Landreth's Filial Therapy
PAT	Planned Activities Training
PCIT	Parent-Child Interaction Therapy
SGPT	Sibling Group Play Therapy
SHPS	Special Home Play Session
SLT	Social Learning Theory
STP	Level-4 Standard Positive Parenting Programme
Triple P	Positive Parenting Programme
VIFT	VanFleet's Individual Filial Therapy

Glossary

Types of Measures

BAS	Behavior Assessment System for Children-Parent Report Form
CBCL	Child Behavior Checklist
C-TRF	Caregiver-Teacher Report Form
ECBI	Eyberg Child Behavior Inventory
DPICS	Dyadic Parent-Child Interaction Coding System
FPC	Filial Problem Checklist
JSCS	Joseph Preschool and Primary Self-Concept Test (p45)
JPSCS	Joseph Picture Self-Concept Scale
MEACI	Measurement of Empathy inAdult-Child Interaction Scale
PBD	Parent Behaviour Diary
PPAS	Porter Parental Acceptance Scale
PRQ	Parent Relationship Questionnaire
PS	Parenting Scale
PSI	Parenting Stress Index
PSI-SF	Parenting Stress Index-Short Form
SDQ	Strengths and Difficulties Questionnaire

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Abstract

Behavioural problems, such as defiance and aggression, are the most common problems presented by children in mental health services. Intervention in these problems, however, failed to develop clinically significant changes in almost one third of the children referred to in the literature. Study 1 was designed to evaluate the effect of Child Parent Relationship Therapy (CPRT) and Level-4 Positive Parenting Programme (Standard Triple P) on children (aged 4-6) with behavioural problems in four families, using a single-subject design. Results indicated that CPRT promoted high levels of parent engagement and increased positive parenting skills, and the therapy reduced child behavioural problems in two families. In the light of the findings, it was decided to investigate CPRT further with a particular examination of whether the gains observed early in the therapy meant that a shorter duration programme may be as effective. The original 10-session CPRT was revised and a manual for a 5-session adapted CPRT was developed by incorporating three key components identified as effective in the intervention. These were (a) deconstruction-and-reconstruction of parents' negative attribution of child behaviour problems; (b) the basic child-centred play strategies; (c) two home visits, one for a live demonstration of child-centred play sessions and another for the supervision and coaching of parent-child play sessions. Study 2 was designed to evaluate the effects of the adapted CPRT on eight parent-child dyads using multiple-baseline single-subject designs and to explore its effects within each family. Observation data revealed a clear relationship between training in intervention strategies and changes in parent behaviour, which resulted in beneficial changes in child behaviour. Visual analysis indicated improvements in targeted child positive and negative behaviours across all children. The pre- and post-intervention analyses suggested that adapted CPRT reduced child behavioural problems and parenting related stress, while improving child self-concept. In contrast to other studies, all the children in Study 2 showed clinically significant improvement in their behaviour and this was maintained at a 3-month follow-up. Discussion includes limitations, implications for clinical practice and future research.

Chapter 1: Introduction

Background

Behavioural problems are the most common problems presented by children in mental health services (Garland et al., 2010). Behavioural problems, such as disobedience, temper-tantrums, hitting and impulsive responses, are typical characteristics of toddlers and young children. In the process of maturity, some children will eventually replace these challenging behaviours with behaviours which are more socially accepted (Campbell, Shaw, & Gilliom, 2000; Keenan & Wakschlag, 2000; Lavigne & Gibbons, 1996). On the contrary, other children, particularly those who displayed a high intensity of behavioural problems in toddlerhood, may continue to engage in the same problematic behaviours during school-age (Fergusson, Lynskey, & Horwood, 1996; Hartas, 2011; Miller-Lewis et al., 2006; Montague, Enders, & Castro, 2005; Richman, Stevenson, & Grahamm, 1982).

Without intervention, child behavioural problems tend to be persistent over time (Bretherton, 2000; Church, 1996; Farris, Nicholson, Borkowski, & Whitman, 2011; Paterson, Carter, Gao, Cowley-Malcolm, & Iusitini, 2008). Moreover, behavioural problems that have their onset in the early years may potentially impair a child's functioning in various aspects (Breitenstein, Hill, & Gross, 2009; California Childcare Health Program, 2006; Sanders, Kirby, Tellegen, & Day, 2014), resulting in continuing difficulties throughout the life of the child. For instance, children who exhibit behavioural problems at an early age are at greater risk of developing behavioural, social and emotional difficulties later in their lives (Goldstein, Harvey, & Friedman-Weieneth, 2007; Hartas, 2011; Montague et al., 2005). Those difficulties include conduct problems, delinquency, substance abuse, criminal behaviours, relationship deficits and family conflict (California Childcare Health Program, 2006; Patterson, Chamberlain, & Reid, 1982; Sanders et al., 2014; Wax, 1976). The above studies indicate that significantly disruptive behaviours in young children are not a transient problem.

Therefore, identifying and thus intervening in behavioural problems in young children are of value (Arslan, DurmuŞOĞLu-Saltali, & Yilmaz, 2011) in order to diminish the long-term consequences.

Despite the historical preventive and remedial approaches for child behavioural problems, generally a form of individual child interventions (Kazdin, 1987), empirically supported approaches for young children with behavioural problems in the recent decades are dominated by behavioural-oriented parent-child interventions (Lees & Ronan, 2008). While more and more evidence-based interventions are now available for this population, behavioural problems in young children continue to receive great attention from researchers and mental health professionals due to their high prevalence and worrying outcomes.

Overview of the Prevalence of Child Behavioural Problems

Behavioural problems among young children are ubiquitous, regardless of the risk factors. A surprisingly large number of children, in many nations, are found to experience some kinds of emotional and behavioural problems each year, making it a worldwide phenomenon. The prevalence of behavioural problems in young children in developed and developing countries is presented as follows.

In the United States of America, between the 1970s and the 1990s, 9.5% to 14.2% of young children under the age of five were estimated to have experienced some kind of behavioural and or emotional disturbances, using varying standardised measures including the *Eyberg Child Behavior Inventory* (Brauner & Stephens, 2006). In the 1990s, 3876 pre-schoolers were screened by 68 private paediatricians during their paediatric visits in Lavigne and Gibbons' study (1996) and 8.3% of the them were found to have severe behavioural problems, with a total behaviour score at or above the 90th percentile, as per the *Child Behavior Checklist* (CBCL). Of that, high prevalences of behaviour problems were found among children aged between four and five years (13.2% and 10%, respectively) and among

boys (10%). In 2005, 16% of parents were recorded as obtaining professional advice concerning their child's behavioural and or emotional problems (U.S. National Centre for Health Statistics, 2005). A more recent National Indicators of Well-Being of the United States Survey estimated that 5% of children aged between four and 17 years experienced some form of severe emotional, behavioural and social difficulties in 2007 and 2008 (Child and Family Statistics, 2010).

In Great Britain, a survey of 307 paediatric out-patients aged between 5 and 15 years, with a mean age of 9.5 years, found that 20.9% and 9.5% of the children were rated by their parents in the 'abnormal' and 'borderline' ranges, respectively, on the *Strengths and Difficulties Questionnaire* (Glazebrook, Hollis, Heussler, Goodman, & Coates, 2003). A prevalence study of 1887 preschool children in Northern Germany found nearly 12.4 % of the pre-schoolers had a total behaviour score at or above the 92th percentile as rated by their parents on CBCL (Furniss, Beyer, & Guggenmos, 2006). Withdrawn and aggressive behaviours were rated as the second and third most frequent issues, respectively, among the preschoolers. Likewise, in Switzerland, 17% and 14.4% of 153 children 5 years of age were rated by their parents in the clinical and borderline ranges, respectively, for conduct problems on the SDQ. Moreover, 11.1% and 4.6% of them had a score in the clinical and borderline ranges for emotional problems, respectively (Perren, Von Wyl, Stadelmann, Bürgin, & Von Klitzing, 2006).

A similar pattern of child behaviour problems was found in Australia. According to an Australian National Survey of Mental Health and Wellbeing in 1998, 14% of children, aged between 4 and 17 years, were reported as having a mental health problem. Of these, 13% of the children were identified as having behavioural problems in the clinical range as per CBCL, at the time of the survey. They included delinquent behaviour (7%), aggressive behaviour (5%), social problems and withdrawal (4%) (Sawyer et al., 2001). Later, the

Australian Bureau of Statistics (2005) found approximately 7% of children aged under 15 years were reported as having some kind of mental and behavioural problems. Of these, 3% were identified with behavioural and or emotional problems. A more recent study by the Australian Institute of Health and Welfare (2010) estimated nearly 3% of the 3.2 million individuals who displayed symptoms of a mental disorder were under the age of 15 years. Statistics for behaviour problems in children aged four to five were provided by the study 'Growing Up in Australia' (Australian Institute of Family Studies, 2011). In that study, 3,740 children aged between 4 and 5 years were rated by their parents, mainly mothers, on the *Strengths and Difficulties Questionnaire*. It indicated that conduct problems were common among 4- and 5-year-olds. In fact, nearly 50% of children showed clear-cut non-compliance, following by temper-tanrums (9.6%) and arguing with adults (6.9%). While emotional symptoms were relatively rare, nearly 10% of children showed nervousness or clinginess in new situations.

In New Zealand, a survey estimated that 9% of school-children who exhibit severe disruptive behaviour are also at risk for mental disorders (New Zealand Council For Education Research, 2008). Two South Island prevalence surveys found approximately 5% of children in primary school, in the 1990s, were antisocial (Bretherton, 2000; Church, 1996). Moreover, around 30% of 7-year-old children in Dunedin were reported by their parents and their teachers as having a high level of behaviour problems on the SDQ, while antisocial behaviour is identified as the most prevalent problem among these children (Bretherton, 2000). In an early prevalence study of behaviour problems, nearly 30% of the 951 7-year-old children were rated by their parents as having serious behaviour problems (McGee, Silva, & Williams, 1984). In addition, approximately 9% of the children were reported by the parents as having persistent behavioural problems, while antisocial behaviour was the most prevalent problem, which was more widespread among boys (22.6%) than girls (14.2%).

The same social phenomenon is shared among developing countries. A cross-national study in the Western Pacific Region indicated 14% and 8.3% of primary school children in Korea and China were identified as "deviant" by their parents and teachers, respectively, on the *Rutter Child Scale* (Matsuura, Okubo, Kojima, & Takahashi, 1993). In addition, 19.1% of Korean children and 7.0% of Chinese children were reported by their parents to be deviant, on the same scale. Even though the prevalence of deviance differs greatly between Chinese and Korean children, a consistently higher prevalence was found among children in both countries, who had (a) lower achievement at school, (b) a single-parent and (c) a parent with lower educational levels. Overall, the prevalence of child behaviour problems in China and Korea as reported in this study is consistent with those found in the prevalence studies in highly developed countries.

Nevertheless, a higher prevalence of child behaviour problems is found in other developing countries. For example, in a study of 1186 Egyptian children aged between 6 and 12 years, 20.6% and 34.7% of them were rated by their parents and teachers, respectively, on SDQ as having emotional and behavioural difficulties (Elhamid, Howe, & Reading, 2009). Of that, nearly 25% of them were reported by both their teachers and parents as exhibiting conduct problems. An even higher level of prevalence of child emotional and behavioural problems was recorded in a study conducted in Pakistan (Syed, Abdul Hussein, & Mahmud, 2007). Of the total of 675 school children aged between 5 and 11 years, 34% of them were rated in the abnormal range by their parents on SDQ. The prevalence of child behavioural problems found in these two studies is relatively higher than that reported in other developing countries, as well as in developed countries.

In regard to the above reviews, 5% to 35% of children were identified as having behavioural problems across nations. Despite the societal effects on ratings, the variations in the prevalence of child behavioural problems may have been contributed to by the application

of different measurements and methodologies in each study. For example, diversity was found across studies in (a) the operational definition for behavioural problems, which in turn affects the inclusion criteria; (b) measurements; (c) children's age groups; (d) children's sexes; (e) demographical backgrounds; and (f) the individual who rates the child's behaviour (e.g., parent, teacher. This literature, even with the variations, has highlighted child behavioural problems as a universal phenomenon and concern. Therefore, serious attention should be devoted to understanding the impacts of children's behavioural problems.

Aetiological Factors of Child Behavioural Problems

To date, numerous longitudinal studies have been carried out to investigate the pathways of early behavioural problems. General agreement has been found among studies regarding the different pathways travelled by children with behavioural problems and the complexity of the interrelation among risk factors. Some studies suggest that a single risk factor is not sufficient in supporting the development of behavioural problems in young children. For example, Shaw and colleagues' (1998) findings showed that the presence of high maternal rejection together with high levels of child non-compliance could largely predict later externalizing problems in young children from low-income families, but both risk factors needed to be present.

The effect of the interplay between risk factors in children and parents on child problematic behaviour found in the above study was also reported in Hughes and Ensor's (2009) study, which included a sample of 235 parent-child dyads from the United Kingdom. Child behaviour was observed by independent oberservers and rated by their parents and teachers, when the children were aged between 2 and 3 years and again when the children were aged between 4 and 5 years. Their findings suggest that child behavioural problems can be predicted when child risk factors, such as poor executive function, which includes the child's planning, working memory performance, inhibitory control, and emotional

understanding, coexist with parent risk factors, such as maternal depression and lack of education. Data from 290 families of young children, between 6 and 9 years of age and who were at risk for conduct problems, suggested that the positive relationship between parental depressive symptoms and children's behavioural problems was mediated by parent-child relational frustration. Moreover, a review of early externalizing behaviour indicated that boys with early negative temperaments, such as high levels of negative affect, are most likely to display persistent behavioural problems if they are exposed to a poor mother-child relationship, limited parental involvement, ineffective parenting strategies and family stressors (Campbell et al., 2000).

The above studies signify the complexity and the damaging effect of the interplay of multiple risk factors on young children's behaviour. There is a wide range of aetiological factors affecting child behavioural problems, such as stressful life events, social demographics, child temperament and child characteristics, parental mental health, family structure and dysfunction and more. However, only factors targeted for parental interventions are further discussed in the following section. They include (a) parenting approaches and (b) parent-child relationships and interactions.

Parenting approaches. Every parent is unique and thus parents his or her children differently. For example, some parents believe in a punitive approach while others use a more caring approach in managing their children. Parenting approaches are generally categorized into four styles, which include authoritarian, authoritative, permissive, and uninvolved parenting (Baumrind, 1966). However, deficit parenting, such as hostile, aversive and inconsistent approaches, are not fully described in Baumrind's parenting style. While inconsistent discipline is a characteristic of permissive parenting, inconsistency in parenting may also present in parents who are hostile and/ or aversive. Regardless of the type of

parenting approach, they each produce an immediate effect as well as a long-term impact on child outcomes, specifically problematic behaviour.

Particular parental practices are found to be risk factors for the development of child behaviour health, regardless of the child's gender. For example, in a longitudinal study of 4,936 children aged between four and five years, Yu, Ziviani, Baxter and Haynes (2010) revealed that low consistency and high hostility in parenting are both risk factors for developing behavioural problems in boys and girls. Similary, Knox, Burkhart and Khuder (2011) found that parental hostility is a strong predictor of aggressive behaviour on CBCL, and conduct problems reported in SDQ, in young children who were receiving some forms of mental health or family services. The negative effect of harsh discipline on behavioural problems was highly persistent in 2- to 6-year-old Pacific Island children who lived in Auckland (Paterson et al., 2008; Paterson, Taylor, Schluter, & Iusitini, 2013). A longitudinal study of 395 families of pre-schoolers in South Australia found that parent self-report of higher levels of over-reactivity, as measured by the *Parenting Scale* (PS), is strongly related to parent- and teacher-reports of child behavioural problems at the age of six years on CBCL, after controlling for all other confounding factors (Miller-Lewis et al., 2006).

Evidence suggests that parenting approaches that are more hostile and less caring not only act as risk factors for developing, but also for maintaining, behavioural problems in young children. For instance, Combs-Ronto, Oslon, Lunkenheimer and Sameroff (2009) assessed 235 children and their parents and teachers when the child was three years of age and again before the child turned six years. Results showed that, higher levels of early negative parenting was related to higher early child externalising behaviour as well as later child externalising behaviour, in parents' and teachers'reports. In that study, negative parenting was a combined measure of the frequency of physical punishment through self-report and observed negative affect during parent-child clean-up tasks, while child

externalising behaviour was measured by CBCL. In addition, a bidirectional relationship was found between early parental negativity and parent- and teacher-reported child externalising behaviour, however no relationship was found between early parental negativity and observed child's noncompliance.

Permissive parenting without limits and uninvolved parenting are also problematic. These types of parenting styles are relatively more common among parents of young children, as compared to other types of negative parenting, such as authoritarian parenting (Ritzi, Ray, & Schumann, 2016), which is commonly paired with hostility, aversive and inconsistent parenting practice. However, their influences on child behavioural problems are less often studied by researchers and thus were not covered in this section.

Studies have found that supportive parental practice is a protective factor for child behavioural problems while the contrary serves as the risk factor. In Pereira, Canavarro, Cardoso and Mendonça's (2009) study, the behaviours of 519 school-age children aged between 8 and 11 years and the child rearing styles of their parents were assessed. The results showed that the parenting styles of both parents in a family were highly alike. More than 30% of the parents reported low support or rejecting-controlling parental practices, which were found to be related to a higher risk of child externalising problems. In contrast, supportive parenting, even when it co-existed with controlling parental practices, related to lower risks of child externalising problems. These findings are similar to those found in an early study of 69 preschoolers and their parents (Denham et al., 2000). In that study, supportive parental practices along with approximate parental control, such as limit setting, served as a protective factor for later behavioural problems, when the child was aged 7 and 9 years, even for those who were initially at risk for behavioural problems during pre-school age. On the other hand, parental anger and hostility were found to be powerful risk factors

for later behavioural problems, especially for those who exhibited behavioural problems during pre-school-age.

The impact of negative and inconsistent parenting on child behaviour could be contrasted with the influence of the alternative, such as non-punitive and consistent approaches. For example, in a large-scale study of 1414 children aged between 4 and 5 years, children who were exposed to less hostile and consistent parenting practices were found to be at lower risk of developing behavioural problems as measured by SDQ (Yu et al., 2010). In Miller-Lewis's (2006) study, parents with higher scores of non-punitive parenting on PS were found to be less likely to have a child with a externalising score above clinical levels at 6 years of age, as rated by the child's teacher on CBCL. Taken together, the above studies underline the beneficial impact of parental positivity in approaches to child behavioural development.

Parent-child relationship and interaction. Both person-centred (Rogers, 1951) and the social learning (Patterson, 1982) approaches to intervention with child behaviour problems emphasise the process of parent-child relationships and interactions as the key influence on a child's and a parent's behaviours. Both of these models recognise that a parent-child dyad produces reciprocated influences on each other on a daily basis. However, there is a theoretical distinction between these models which underlines the different pathways travelled by children with behavioural problems. The perspectives of person-centred therapy and social learning theory on the development of child behaviour problems are briefly discussed and followed by related empirical studies.

According to Rogers (1961), the quality of a relationship, which is therapeutic, is the basic element which facilitates a person to behave constructively or otherwise. In regard to his conceptual model, a child's, as well as a parent's, behaviour could be determined by the quality of their relationship, which is decribed as follows. When a boy who is holding a toy

car pushes his little sister who is approaching him and intends to touch the toy car, his sister cries. The boy's behaviour is perceived as a response towards his current experience. In this circumstance, a mother may pick up her crying daughter and scold her son for his behaviour or even perform physical punishment. The mother-son relationship at the time is featured by a lack of parental understanding and acceptance. The boy may feel his inner need is devalued by the mother and thus a threat to his positive concept of self. Subsequently, the boy may be psychologically defensive, either denying or distorting his experience, which initially helps him to maintain a state of psychological stability. However, when this occurs, the boy's behaviour will no longer be consistent with his inner concept of self, and thus becomes deconstructive, which is usually manifested through a form of negative, immature, and anti-social conduct, such as yelling at the mother or hitting his little sister. Rogers conceptualised that a child's deconstructive behaviour could be summarised as a child's psychologically defensive act toward his or her experiences which threaten the child's positive concept of self. This causes the beginning of an incongruent child, which, in fact, suppresses the child's tendency for growth in the long run (Rogers, 1939, 1951).

On the other hand, Patterson (1982) claims that the coercive interchange between a parent-child dyad, which starts during infancy, is the beginning of a chain of anti-social behaviour developing in a child. Coercion theory was developed within social-learning theory (Bandura, 1977) by Patterson (1982), who emphasises that the contingencies between a parent-child dyad are interchangeably strengthened and amend each other's behaviours in the process of socialization. For example, a boy creates an aversive condition for his mother by screaming when he is not allowed to have an ice-cream. Then, the mother reacts to remove the aversive behaviour– to stop her son from screaming– by giving into his demand by offering him an ice-cream. This reinforces the aversive behaviour and the maternal response through negative reinforcement (both the maternal demand and the child's aversive

behaviour are removed), thus creating an escape response from an aversive event which is extremely resistant to change over time (Patterson, 1982). In the above example, the parent is negatively reinforced by escape; the child is both positively and negatively reinforced by escape (parent yields) and by getting the reinforcer. The parent and the child are both trapped under the same contingencies. Over time, this interchange of negative reinforcement within the dyad becomes a powerful mechanism that increases and maintains the level of coercion.

In two early studies, some parental approaches were used as constructs to indicate the quality of care-giving and thus the effects on child behaviour. Shaw and colleagues (1998) reported a strong negative relationship between maternal responsiveness and child behavioural problems in a 3-year longitudinal study of 130 mother-child dyads. The findings suggested that maternal rejection, which was defined as negative maternal responses and characterised by a low quality of parent-child relationship, was the most persistent predictor of child behavioural problems, for both girls and boys. Later, the researchers (Shaw, Owens, Giovannelli, & Winslow, 2001) furthered their efforts in determining the pathways of early externalizing disorders by following 310 boys from infancy until 6 years of age. Findings suggested that infants who experienced low quality of care-giving and rejection from parents were more likely to display destructive behaviour in the clinical range later in their lives at school-entry. The researchers captured the damaging impact of negative parental responsiveness on child behaviour development in two different studies and populations.

The influence of the parent-child relationship and interaction on child behaviour is described, at least to a certain extent, in some studies. In DeKlyen, Speltz, and Greenberg's (1998) study, 55 psychiatry referrals and 55 normally developing boys, aged between 4.0 and 5.5 years, and their parents were assessed. Study results showed that the boys with insecure attachment to either of their parents were 5 times more likely to be clinic-referred than those with secure attachment. In addition, early onset of conduct problems was found to be

strongly related to a low quality of father-child relationship, through father-self-report as well as observed father-child interaction. A 6-year longitudinal study of 825 Pacific fathers in New Zealand found that child behavioural problems in early years are positively related to lower involvement of a father in the family (Tautolo, Schluter, & Paterson, 2015). The findings in both studies provide some insights into the role of parental involvement in and the quality of affection within the parent-child relationship, especially among fathers, in contributing to the development of child behaviour and functioning.

In fact, family affective environment is an important factor that influences a child's behavioural development (R. Barry & Kochanska, 2010). In that study, 102 two-parent families of 7-month-old infants were followed over five years until the children turned 67 months. The findings indicated that higher marital satisfaction among parents predicted greater affection in fathers and greater joy in mothers, which, in turn, positively influences the parent-parent relationship as well as the parent-child relationship. While parent anger was related to greater anger within- and across-dyad, joy within the parent-child dyad did not have a cross-dyad effect on the parent-parent relationship. Interestingly, a positive relationship was found between children's affectionate behaviour to fathers and mothers' affectionate behaviour to the child. The results suggest that each family member's positive as well as negative emotion is conveyed through his or her interaction either within- or across-the family relationship.

Likewise, Schermerhorn, Cummings and Davies (2008) suggested that higher levels of marital satisfaction were related to greater expression of positive affect in parent-child interactions. For example, mothers and fathers with higher marital satisfaction have been found to have greater joy in, and greater positive affect towards, their children, respectively. These findings suggest that marital satisfaction was related to positive expressions of emotion in parent-child dyads, which in turn provide a healthy ground for optimal child development.

The findings indicated that a father-child attachment relationship was sensitive to family context. Insofar as the evidence suggests, lower levels of marital satisfaction and higher levels of marital conflict may increase the levels of dysfunction in parents' behaviour and the parent-child relationship, thereby leading to behavioural problems in young children. The authors suggested that negative family context could act as a risk, while the opposite could be a resilience factor, for children's behavioural outcomes. In addition, based on the stability of the sense of security in mother-child relationships, the authors suggested that it is important to address any relationship problems between mother and child as early as possible, in order to prevent the maintenance of negative representations.

Furthermore, some studies have revealed the possible long-term impact of parental emotional expression on child behaviour. For instance, longitudinal data of 35 married two-parent families of pre-schoolers aged between 3 and 5 years suggested that high levels of negative expressiveness and low levels of positive expressiveness of mothers strengthened the connection between maternal negative emotionality and child behavioural problems, while the high levels of positive expressiveness of mothers weakened the relationship (Slatcher & Trentacosta, 2012). In particular, children whose mothers reported high negative emotionality when the children were around four years of age were at higher risk for behavioural problems in the following year, including whining, arguing, fighting and using negative emotion words than those whose mothers reported low negative emotionality. Interestingly, children were found to react differently towards fathers' negative emotionality in this study. For example, children of fathers who rated themselves high in negative emotionality displayed relatively more whining (3 times) and crying (2 times) than those fathers who reported low negative emotionality. Another 2-year longitudinal study of 150 families and infants showed that, regardless of the parenting behaviours, when they were delivered with a positive emotional tone they would foster a better self-regulation in their

children, when they reached the age of 4.5 years (Cipriano & Stifter, 2010). These findings indicated that some observed parenting behaviours, including redirection, explanation, social exchange and the granting of wishes, even though positive, may be less effective without parental warmth, including positive emotions and a caring expression. Likewise, a 4-year longitudinal study of 69 pre-schoolers found that observed parental anger, when the child was aged between 4 and 5 years, was related to greater externalizing problems in the child two and four years later. Whereas, parenting practice which featured a nurturing, child-centred and de-emphasis on harsh approaches, was found to be the strongest predictor of decreasing externalizing problems (Denham et al., 2000). The above studies signified the importance of parental emotion expression as an element in parent-child interaction and relationship which, in turn, partially determines the direction of the child's behavioural development.

The above studies highlighted the importance of the quality of parent-child relationships and interactions in early childhood for later child behaviour outcomes. The parent-child relationship is measured in some of the studies reviewed, but not in the way defined by Rogers (1939). The positive and negative parental constructs have provided insight into the influences of different qualities of parent-child interactions and relationships on the development of child behavioural problems. Therefore, these studies, to some extent, support Rogers' and Patterson's concepts, which identify parent-child relationships and parent-child interchanges as risk factors, if they are negative, and resilience factors, if they are positive, for healthy behavioural development in young children.

Impacts of Child Behavioural Problems

Behavioural problems could negatively impact many different aspects of young children and their parents, including cognitive, social and emotional functioning. They are commonly manifested through the children's learning and academic processes, social relationships, and perception of self or self-esteem. As for parents, the impacts might be

exhibited through their parenting styles, parenting stress, mental health and social relationships. Aligned with the central interest of this thesis in parent-child interventions, the impacts of behaviour problems on child self-concept, parenting stress and parent-child relationship were particularly considered in the present study. These constructs are discussed as follows.

Impact on child self-concept. A large proportion of preschool children with behavioural problems perceive themselves negatively (Breitenstein et al., 2009; Webster-Stratton & Herbert, 1994). Reykowski and Jarymowicz (1976, in Cauley & Tyler, 1989) discovered that children who experience low levels of self-esteem are more likely to exhibit reduced pro-social behaviour than those with high levels of self-esteem. This finding was supported by a later study of 52 children aged between 4 and 5 years. In that study, Cauley and Tyler (1989) found that child-reports of self-concept, as measured by the *Purdue Self-Concept Scale for PreschoolChildren,* were strongly related to the cooperative behaviour during free play as reported by independent observers. Children with high levels of positive self-concept displayed more cooperative behaviour than those who had lower levels. Moreover, in a community sample of children aged between 7 and 11 years, Ha, Peterson and Sharp (2008) found that child-reports of low-self-esteem, *as per the Rosenberg Self-Esteem Scale,* were negatively associated with the child- and teacher-reports of conduct problems on SDQ. Likewise, data from 98 school-aged children who were at risk for severe antisocial and aggressive behaviours indicated a negative correlation between self-esteem, as measured by the self-esteem subscale of the *Behavioral Assessment System for Children Self-Report of Personality*, and conduct problems among younger children (C. Barry, Frick, & Killian, 2003). Considered together, the findings of these studies indicate an inter-correlation between the way a child perceives himself and the way the child behaves, especially in young children.

The interplay between behavioural problems and self-esteem, within the context of social relationships, was further described in a review of the dysfunctional effects of low-self-esteem in children. In this study, Leary, Schreindorfer and Haupt (1995) defined self-esteem as "the internal gauge that monitors the likehood that one will be included and excluded" (p. 298). They explained that perceived social rejection may underlie aggression in a child, while the child's further maladaptive effort to obtain social inclusion may lead to more dismissive social experiences that ultimately threaten his or her self-esteem. With respect to this assumption, children who encounter unsuccessful social experiences due to their own problematic conduct are more likely to experience low-self-esteem.

The above studies suggested there is a negative association between behavioural problems and self-concept or self-esteem in young children. While self-concept and self-esteem are two different constructs, which are assessed by different measures, they are commonly discussed together (e.g., Davis-Kean & Sandler, 2001; Luhtanen & Crocker, 1992). This is beacause they both share similar aspects of one's self, which has been well described by Davis-Kean and Sandler as "it is difficult to create a self-concept measure that taps into only the descriptive and not the evaluative aspect of the self (Davis-Kean & Sandler, 2001, p. 888). As self-esteem is the value one imposes on his or her self-concept, the terms 'self-esteem' and 'self-concept' are discussed together and used interchangeably in this thesis.

Impacts on parenting stress and its consequences. Behavioural problems in young children are challenging for those in their social systems, especially parents. Studies have found that handling problematic behaviour, particularly non-compliance, aggression, temper-tantrums and conduct problems, may intensify parental stress, especially when the parents were struggling economically and have mental health problems themselves, or were solo parents (Anthony et al., 2005; Broadhead, Chilton, & Crichton, 2009; Kazdin, 1995). Other

studies have suggested that the effect of child behavioural problems on parental stress has been found in both single parents and two-parent families. For instance, in an earlier study of 165 children aged between 2 and 10 years, Eyberg, Boggs and Rodriguez (1992) found that maternal reports of stress on *Parenting Stress Index* (PSI) was strongly related to maternal-reports of child behavioural problems in clinically significant ranges on *Eyberg Child Behavior Inventory* (ECBI) among mothers, either from single-parent or two-parent families. A recent study of 237 children aged between 3 and 9 years and their parents indicated that parenting stress was a consequence of child behavioural problems (Neece, Green, & Baker, 2012). Similarly, Anthony et al. (2005) found a strong positive relationship between parent-reports of stress on *Parent Stress Index –Short Form* (PSI-SF) and teacher-reports of child behaviour problems among 229 preschoolers. Moreover, the findings indicated that parenting stress intensifies child behavioural problems, if the parent has high expectations of their children.

Child behavioural problems could also intensify social stressors and may result in social withdrawal in parents. The stress of parenting a child with behavioural problems could evoke psychological distress among parents (Meadows, McLanahan, & Brooks-Gunn, 2007; Tan & Rey, 2005; Zajicek-Farber, Mayer, & Daughtery, 2012), especially when social support is reduced. For example, studies found that children with high levels of behaviour problems may affect other people within their social environment, by creating high levels of tension for the people around them (Breitenstein et al., 2009; Broadhead et al., 2009). To avoid similar occurrences, the parents will gradually reduce their participation in social gatherings, which in turn, reduces their opportunities to receive support from their social network (CY Lee, Lee, & August, 2011). This downward spiral of coercive family processes was well explained by Patterson (1982) and illustrated through his ‘vile weed’ drawing (p. 13). For example, a child who throws a temper-tantrum in a social gathering

creates an aversive atmosphere in the setting. It is both annoying and stressful for others in that social environment. For parents, handling an 'angry' child in public is challenging, while failure in managing the child's anger is somehow embarrassing, thus heightening their stress levels. As a result, the parents are more likely to withdraw from their social networks.

Without sufficient social support, parenting a child with severe behavioural problems may jeopardise the overall marital relationship. For example, these parents would have to support each other in parenting. However, if both parents are inadequate in parenting, they may experience more failures in parenting and conflicts over child rearing (Salari, Wells, & Sarkadi, 2014). This may, in turn, impact their marital relationship (R. Barry & Kochanska, 2010). Studies reported that high levels of conflict over child rearing, parental dissatisfaction and marital distress were positively related to child behavioural problems (Gattis, Simpson, & Christensen, 2008; Salari et al., 2014). Conflict between parents may directly impact the family relationship and their mental health, if it is not dealt with constructively (Fisher, Brock, O'Hara, Kopelman, & Stuart, 2015; McCoy, George, Cummings, & Davies, 2013).

Impacts on the parent-child relationship. Pardini (2008) emphasised the importance of recognising the bi-directionality between child behaviour and development and the mutual influence of parents and children in their relationships. Studies consistently indicated a negative relationship between children's behavioural problems and the quality of their social relationships, especially in parent-child relationships. However, most of these studies highlighted the one-way influence a parent has on his or her child's behaviour (e.g., Gharehbaghy, 2010; Kochanska & Kim, 2014). Research that examines the child's impact on parents is relatively rare. In a longitudinal study, Shaw et al. (2001) followed 310 infants and their mothers for 6 years. The findings indicated that mothers of children who displayed destructive behaviour during toddlerhood (ages 2 to 3.5), demonstrated high levels of rejection and less caring toward their children during laboratory and home observations,

respectively, when the children were aged 5.5. This indicated that child destructive behaviour has an impact on the parent-child relationship, particularly the quality of caregiving, including warmth, hostility and verbal or physical approval.

Persistent behavioural problems in young children may potentially influence parents' involvement in their children's social and learning activities. For example, some parents, especially fathers, of children with significant behavioural problems may maintain a distance from the family by becoming less sensitive towards the emotional needs of others in the family or even reducing their engagement with their children, including playing, parenting and caretaking (Pazzagli et al., 2014; Torres, Veríssimo, Monteiro, Ribeiro, & Santos, 2014). In addition, a study of 129 preschoolers in two urban areas in England found that parent-reports of child behavioural problems were negatively associated with the parents' involvement in the children's school activities (Tichovolsky, Arnold, & Baker, 2013).

Overview of Parent Interventions for Child Behavioural and Emotional Problems.

In the present study, parent interventions are referred to as psychological parent training programmes or as a form of parent-child intervention. Parent interventions are specifically designed to train parents to reduce behavioural and emotional problems in their young children. They either aim to alter parenting skills, to enhance parent-child relationships or a combination of both. Some studies have indicated that younger children will benefit more from psychological interventions (e.g., Bayer et al., 2009; Weisz, Weiss, Alickle, & Klotz, 1987), particularly when their parents are included in the interventions (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015). This indicates that parents could be an effective change agent for their children with behavioural and emotional problems. Forehand, Jones, and Parent (2013) indicated that, owing to developmental considerations, parent interventions are favoured over child psychotherapies for child disruptive behaviour which often take place in the preschool years. In addition, they

suggested that young children are less suitable to be the primary clients to learn to control their own behaviour compared to their parents.

Among some early versions of parent interventions, two were developed in the 1960s and 1970s to train parents to manage their child's emotional and behavioural problems. These are filial therapy (FT), developed by Bernard Guerney (1964) and modelled after the person-centred framework of Rogers (1951), and 'behavioural parent training' (BPT) which was founded by Patterson (1982) in reference to the social learning theory (SLT) of Bandura and Walters (1963). Both FT and BPT have led to the comprehensive development of parent programmes as well as parent-child interventions. As a result, more modalities of parent or parent-child intervention, which require parents' active involvement in addressing their child's issues, have been introduced in recent decades. They include, but are not limited to, Incredible Years (IY), Parent-Child Interaction Therapy (PCIT) and Positive Parenting Programme (Triple P), which are all generally categorised as a form of behavioural-oriented parent intervention, as well as FT and Child Parent Relationship Therapy (CPRT), which are regarded as forms of relationship-oriented parent intervention.

It is important to note that behavioural-oriented parent intervention is focused on addressing child behavioural problems through improved parenting skills, while relationship-oriented parent intervention is aimed at addressing child emotional problems through an improved parent-child relationship. This has been reflected in a review of evidence-based psychosocial treatments for children with disruptive behaviour (Eyberg, Nelson, & Boggs, 2008). In the review, parent interventions, which were identified as a well-established treatment or a probably efficacious treatment, are all categorised as a form of behavioural-orientated interventions. They include Parent Management Training (PMT), Helping the Noncompliant Child, Incredible Years-Parent Training (IY-PT), PCIT and Triple P. Given that a large number of outcome studies of FT indicated positive changes in child behaviour

following intervention; it is suggested in the review as a prospective intervention for parents of children with behavioural problems. Moreover, Bratton et al. (2005) reported a moderate to large positive effect (*ES*=0.78) of play and filial therapy on child externalising behaviour across 17 studies. However, at the time of the review in 2008 (Eyberg et al., 2008), there were only a limited number of FT studies that used methodologically sound research designs which met the criteria for well-established treatment or a probably efficacious treatment. In addition, few of these studies involved children with diagnosed or clinical levels of behavioural problems. This lack of rigor in the FT studies affected any conclusions that could have been drawn regarding the effectiveness of FT for child behavioural problems, in particular.

Chapter 2: Literature Review

Behavioural problems in young children often require timely professional resolution (McGee et al., 1984) otherwise, without intervention, they tend to be persistent over time (Bretherton, 2000; Church, 1996; Farris et al., 2011; Paterson et al., 2008). As aforementioned, behavioural problems might have negative impact on a child's normal development and functioning. However, a child's behaviour is not fixed; therefore, it provides a window for intervention. Moreover, the existence of child behavioural problems and their overwhelming negative impacts on society have warranted the development and implementation of effective psychological interventions in diminishing their long-term damaging impacts. A small number of child interventions for child behavioural problems have been identified in meta-analysis studies of child and adolescent psychotherapy (Casey & Berman, 1985; Weisz et al., 1987), while others are forms of parenting programme, which have commonly employed behavioural approaches, cognitive behavioural approaches and mixed behavioural techniques (C. Lee, Horvath, & Hunsley, 2013).

Individual Child Play Therapy

Filial therapy or CPRT was grounded in the principle of child-centred play therapy (CCPT). Regardless of theoretical orientations, play therapy is most commonly delivered as an individual child intervention for child behavioural and emotional difficulties, especially for young children. (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990).

In the early 1920s, some psychoanalysts, for example Sigmund Freud, Anna Freud and Melanie Klein, hypothesised the systematic use of play as an approach, which is equivalent to free association in adult therapy, to help children overcome emotional trauma (B. Guerney, Guerney, & Andronico, 1966; Howard & McInnes, 2013; M. Porter, Hernandez-Reif, & Jessee, 2009). In addition, Anna Freud used play during therapy as a means of establishing an emotional connection with the child which was deemed to be positive and influential (B.

Guerney et al., 1966; Howard & McInnes, 2013). Theoretically, these psychoanalysts believed that child behaviour problems were external symptoms of internal conflicts.

In the 1940s, there was a conceptual change from the intrapersonal focus of psychoanalysis to an interpersonal focus which emphasises the child-therapist relationship in humanistic theories and therapies (B. Guerney et al., 1966). A complete paradigm shift in play therapy was consolidated by the development of person-centred therapy (Rogers, 1951). For example, Axline (1947) used the concepts of person-centred therapy as a theoretical guidance to conceptualise and facilitate the therapeutic process with children during play therapy. Learning from Rogers, Axline (1947) used non-directive play as a natural means of self-expression for children to replace verbal expression of adults in person-centred therapy. Play is also used as a means for a therapeutic relationship between the therapist and child in Axline's (1947) non-directive play therapy. Scholars acknowledged that individual child play therapy drives the child towards positive changes in behaviour by promoting child self-understanding within a therapeutic relationship between a therapist and a child (Axline, 1947; Eyberg, 1988).

Non-directive play therapy or unstructured play therapy, later known as child-centred play therapy (CCPT) (LeBlanc & Ritchie, 2001), was developed by Axline (1947) as an integration of play and the central principles of Rogers' person-centred theory (1951) in establishing a therapeutic relationship between the therapist and child to release the child's constructive force towards positivity. As in person-centred therapy, the three basic attitudes of a therapist, namely genuine, unconditional positive regard, and empathetic understanding, are essential in establishing the therapeutic relationship between therapist and client.

To convey the three attitudes of the person-centred therapist, CCPT therapists use some specific strategies to respond to the child's play, such as behaviour tracking, and verbally reflecting the child's feelings and intentions to facilitate emotional and behavioural regulation

in the child, in addition to the non-verbal expression, such as attentiveness, showing interest, and allowing the child to lead the play sessions (Axline, 1947, 1969). As an example of behavioural tracking, a therapist might say, *"You threw it over there"* after the child throws a doll next to a high chair. In this way, the therapist describes the child's action without naming the specific items used by the child, to accomplish that action, for instance the doll is verbalised as "it" and the high chair as "there". Without identifying the name of the particular objects used by the child and emphasising action, the therapist allows the child to be fully creative in his or her play.

Another strategy is reflecting the child's expressed thoughts and feelings without interpreting the child's behaviour to the child. For example, a boy says "*Urgg!*" and stamps his foot, when he unable to open the lid of a playdough bottle. The therapist might say, "*You are angry that you can't get it open*". Another example of reflection a therapist may use, when a girl is humming when she is playing with a doll, is to say "*You are happy playing with it*". When the therapist reflects what the child sees and feels, the child would feel understood and accepted by the therapist, and thus reduce his or her need for defensiveness while increasing his or her self-understanding, self-acceptance and positive self-concept. Through the therapist's use of reflection, the child would learn that his or her real-self and all his or her feelings, positive or negative, are reasonable and acceptable and therefore his or her needs and feelings are no longer a threat that needs to be repressed or distorted.

The therapeutic relationship is established between the therapist and the child when the basic attitudues of person-centred therapy are conveyed by the therapist using specific skills and are perceived by the child. As a result, the child embarks on constructiveness and positivity. For example, the child would reduce their need for defensiveness and distortion towards self and others when they perceived their self as being genuinely accepted and understood by the therapist. The child would then freely express and explore him or herself

through play which has been avoided or restricted. The unconditional positive regard and acceptance conveyed by the therapist helped the child increase their self-acceptance and positive self-regard through an improved self-understanding. Consequently, the child would increase their openness towards self and others, which would demonstrate positivity through behaviours and attitudes.

Child-centred play therapy adapted the therapeutic relationship of person-centred therapy by including therapeutic limits. To be concise, the CCPT therapists accept all symbolic expressions and behaviours of children in play therapy, regardless of their contents, but not socially undesirable behaviours, such as aggression towards others. The therapist accepts the child's needs or desires for expression by facilitating the child to channel disruptive acts into symbolic means. By using therapeutic limits, the therapist encourages emotional and behavioural regulation by helping the child to differentiate between desires and conduct (Axline, 1947; Ginott, 1959). For example, when a boy looks at therapist angrily and aims a dart gun at the therapist, the therapist would first acknowledge and reflect the child's desire by saying "*I know you are angry at me*"and then communicate the limit clearly that "*people are not for shooting at*" and follow this by redirecting the child to a symbolic alternative, such as to "*you can aim at or to shoot at the bop bag and pretending that is me*".

In particular, Axline (1969) suggested eight principles to be followed by play therapists in forming the therapeutic relationship in play sessions. These are: (a) developing a bond with the child; (b) accepting the child as he or she is; (c) initiating a non-judgemental relationship to support the child to fully express his or herself; (d) identifying and verbally reflecting the child's feelings; (e) valuing the child's ability for productive change; (f) allowing the child to direct the sessions and thus enter the healing process; (g) being patient and not rushing the child in the therapy process; and (h) implementing consistent and therapeutic limits to anchor

therapy to reality. These principles are embedded in CCPT to initiate the self-understanding and self-confidence that lead to positive self-directed change in the child.

In the 1960s, cognitive-behavioural play therapy (CBPT) was developed with the combination of the principles of cognitive therapy (CT) and behavioural techniques for young children under the age of eight years (M. Porter et al., 2009). Studies of CBPT with pre-schoolers have been carried out and published since 1990 (Knell, 1998). The principle of cognitive therapy is to help individuals to obtain behavioural changes by altering their distorted thoughts underlying their behaviours or boosting adaptive beliefs, which are absent. It uses modelling, reinforcement and role-play to obtain changes in children's behaviours. Cognitive-behavioural play therapy is therapist-directed and structured with specific play materials chosen by a therapist for an individual child based on the therapist's knowledge of the child's issues and situations. Play is used as a medium to teach coping and problem-solving skills through modelling and role-play. Through toy-modelling, CBPT allows children to re-experience their problem situations with a new set of positive self-statements and adaptive behaviour (Knell, 1998; Knell & Dasari, 2010; M. Porter et al., 2009). Role-play is used for children to practise new skills with the therapist, which is more effective with school-aged children. Later, some researchers, for example Knell (in Knell & Dasari, 2010), extended the practice of CBPT to alter a child's environment, thoughts and fantasies (M. Porter et al., 2009; Russ, 1998).

There are a few differences between CBPT and CCPT. First, the use of play and toys differs. In CBPT, toys are used as tools by the therapist to model coping statements and coping skills for the child to internalise them during play sessions. For example, when working with a child with separation anxiety, a CBPT therapist uses a child-puppet to verbalise the child's anxiety along with a positive statement, such as "*I am scared, but I know my mum will pick me up after school*" while the child-puppet is waving to her mum-puppet

and approaching the school. On the other hand, in CCPT, toys are used to enrich children's directive expression of self during play sessions. A child is free to choose any toys to represent anything during play sessions, without any restrictions, encouragement or clues from the therapist. For example, a child might use a doll or a dinosaur to express his or herself during play sessions. In addition, CBPT does not seek to eliminate the child's verbal expression in the therapy as in CCPT. A child's verbal ability remains as a therapeutic element in CBPT; for instance a child would be praised for talking about difficult feelings, although play is considered as as a developmentally appropriate means to engage a young child in the therapy. However, a child's verbal self-expression is less emphasised in CCPT (Foulkrod & Davenport, 2010).

Second, while a child's disruptive action is not permitted during therapy in both CBPT and CCPT, they use a different approach to this. While CCPT uses therapeutic limits to redirect the child's acting out behaviour into an alternative symbolic deed through play, CBPT helps the child to identify the negative emotion and thus express it using words rather than behaviour in addition to behaviour modification. Third, CBPT is therapist-oriented while CCPT is child-oriented. A cognitive-behavioural play therapist would introduce play themes by selecting a set of toys and directing the child's play. For CBPT, with the information provided by parents and teachers, the therapist uses a puppet to act as the child and to verbalise the child's issues as well as to introduce goals for the child. For CCPT, the therapist follows the child's lead and allows the child to choose toys and implicit goals.

Finally, a selection of play materials are provided in the playroom in CCPT and children are not allowed to bring their own toys into the playroom or to take home any play materials in the playroom. However, children are allowed to bring significant materials or toys in CBPT. For example, a child with toilet training issues is allowed to bring a real potty to the sessions. While play is used as a medium of therapy in both CCPT and CBPT, the

fundamental theoretical difference between CCPT and CBPT is that in CCPT the basis of healing is in the child-therapist relationship while in CBPT the premise is to address and solve the child's problems or problem behaviours. In terms of practice, the fundamental difference between CCPT and CBPT is grounded in the therapist's and child's levels of directedness in toys selection, toy used, play and goal setting, during play sessions.

There have been three meta-analytical reviews specifically about play and filial therapy (e.g., Bratton et al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015) and some recently published play therapy studies; thus informing the overall effectiveness of play intervention as well as the specific play therapy modalities. However, each of these meta-analytical reviews also includes studies in which play therapy was delivered by parents, if the child is the primary focus of the treatment. The discussion of these three meta-analytical studies is in the following section highlighted a) the overall effectiveness of play therapy on children, in general; b) its effectiveness on children with behavioural problems, in addition to the difference in effectiveness when different theoretical orientation was used in play therapy.

In the earliest meta-analysis of play therapy, LeBlanc and Ritchie (2001) reviewed 42 published and unpublished single-case and controlled-outcome studies of play therapy dating from 1950 to 1996. These studies included children aged between 0 and 12 years who exhibited a range of issues, including behavioural problems. The modality of play interventions used in the studies was coded as (a) directive, including directive play therapy or CBPT, story therapy and guided imagery therapy; (b) nondirective, including nondirective play therapy or CCPT; and (c) play therapy with specific tools, such as using puppets and board games. An overall medium effect (d = 0.66) on child outcome was found when therapy was extended to approximately 13 sessions. A medium effect size (d = 0.56) was also found in individual therapist-delivered child play therapy. The largest effect size was found when therapy was extended to approximately 30 sessions, while a negligible effect size

was found in play interventions which were fewer than 10 sessions, particularly in individual child play therapy and play intervention conducted by therapists. Effect sizes were consistent across gender, age, presenting problem and mode of delivery, either individual or group.

Later, Bratton, Ray, Rhine and Jones (2005) reviewed 93 published and unpublished controlled-outcome studies, dating from 1950 to 1996, to determine the total effectiveness of play intervention on child externalising and internalising problems and the factors that moderate its effectiveness. In this review, 78% of the studies were coded as humanistic-nondirective, including child-centred approaches, while others were coded as non-humanistic-directive, including behavioural, cognitive, and directive forms of PT with the use of specific toys and games. An overall large effect size was revealed for PT with children (d = 0.80), with a medium to large effect size found for PT conducted by a professional therapist, (d = 0.72) and for child externalising behaviours (d = 0.78).

A number of factors were found to impact the effectiveness of PT in this review. First, similarly to LeBlanc and Ritchie's (2001) findings, the duration of interventions was found to be related to treatment outcome. A maximum effect was found for play intervention that had at least 35 to 40 sessions, while a small treatment effect was found for play intervention that had fewer than 14 sessions. Second, in terms of treatment orientation, a relatively larger effect was found in humanistic-nondirective play intervention, including CCPT, (d = 0.92) than in non-humanistic-directive play intervention, including CBPT, (d = 0.71), using the same procedures to compute treatment effects as some earlier reviews (e.g., Casey & Berman, 1985; Weisz et al., 1995). Finally, in terms of setting, a larger effect size was found in interventions delivered in residential settings (d = 1.10) compared to those conducted in schools (d = 0.69) and clinics (d = 0.81).

In a recent meta-analysis, Lin and Bratton (2015) reviewed 52 controlled outcome studies, dating from 1995 to 2010, to determine the specific effectiveness of CCPT. In

addition to therapist-delivered play therapy, teacher-delivered and parent-delivered play therapy models were included in the analysis. Using the statistical weighted hierarchical linear modelling, a moderate treatment effect (*ES*=.47) was found for treatment with young children (*M*=6.7 years) who received CCPT. Unlike the previous meta-analyses (e.g., Bratton et al., 2005; LeBlanc & Ritchie, 2001), results in this review showed that CCPT had larger effects on children aged seven years and younger (*ES*=.53) than on those who were older (*ES*=.21). In terms of child presenting issues, CCPT demonstrated a significantly smaller effect on children with externalising behavioural problems than all other issues, including internalising behavioural problems, relationship issues and self-esteem, which were not found in the previous meta-analytical reviews of play therapy. While no significant difference in treatment effects on child presenting problems was found in Bratton et al.'s (2005) review, an overall large treatment effect was found on child externalising and internalising behavioural problems. Consistent with the LeBlanc and Ritchie's (2001) and Bratton et al.'s (2005) findings, Lin and Bratton (2015) found that play therapy, if delivered by parents (*ES*=.59) through FT, is relatively more effective for children than that conducted by mental health professionals (*ES*=.33). These findings highlighted the positive impact of parent direct involvement on child presenting problems when play therapy was implemented.

The above meta-analyses indicated that play therapy is generally beneficial for children. While play therapy is shown to be effective for children with different ages and presenting problems, regardless of treatment modalities, CCPT was found to be relatively more effective in addressing the caregiver-child relationship issue and low self-esteem in children, than it was for child behavioural problems or with younger children. Consistently, the above reviews indicated that play therapy delivered by parents trained in FT produced better outcomes for their children than play therapy conducted by mental health professionals.

In a recent randomised controlled-outcome study, Bratton et al. (2013) investigated the effect of CCPT on 54 preschool children aged between 3 and 4 years, with borderline or clinical levels of disruptive behaviors, from low-income families. Twenty-seven children in the experimental group received an average of 20 sessions of CCPT, while children in the active-control group received the same number and duration of reading mentoring sessions. Each session lasted for 30 minutes and was offered twice weekly. Children in the experimental group showed a statistically significant reduction in externalising behaviour, aggression and attention problems in the classroom over time on *Caregiver-Teacher Report Form* (C-TRF) compared to those in the active-control group. In particular, seven and 13 children who were rated at clinical and borderline levels of disruptive behaviours at pre-intervention, respectively, moved to the normative range following CCPT, while only five children showed clinically significant improvement following reading mentoring.

The effectiveness of Adlerian play therapy on child behavioural problems was investigated using a single-subject design with three children, with a waitlist-control case(Meany-Walen, Bratton, & Kottman, 2014). Two children received at least 15 play sessions of 30-minutes each in eight weeks, while the other child received no play sessions during the waiting period. The observation data demonstrated clear improvements in one out of the two experimental children's on-task and total problem behaviours, while the control child showed a high variability for her on-task behaviour and an increasing trend in her total problem behaviour over the course of the study. Given the low number of three to four data points collected from the experimental children during baseline, and the moderate variability in the on-task and total problem behaviours of one experimental child, the researchers' conclusion as to positive effect of Adlerian play therapy on child behavioural problems was not justified.

In another recent single-subject study of play therapy, the effect of CCPT on children with Austism Spectrum Disorder (ASD) was researched (Ware Balch & Ray, 2015). A total of five children, aged between 6 and 8 years, participated. They received a varied number of play sessions delivered by a therapist ranging from 12 to 22 sessions, each for 30 minutes. During the intervention phase, all children improved in parent-reported social competence. In particular, a moderate treatment effect on child empathy was found in three children and a moderate treatment effect on child self-regulation and responsibility was found in two children, based on the non-overlap method of analysis. It is worth noting that two children who obtained positive but weak treatment effects on all subscales, while engaged in longer intervention phases and who received at least 20 play sessions, were those who had the lowest levels of baseline functioning. This indicates that low functioning children with ASD may benefit from a relatively greater number of play sessions than those with higher levels of functioning. This study demonstrated that CCPT can effectively engage low-functioning children with difficulties behaviours associated with ASD.

The effect of CCPT on the behavioural problems of children with intellectual disabilities was also studied using a single-subject design (Swan & Ray, 2014). Two children aged between six and seven years in this study received a total of 15 CCPT sessions in five weeks, each lasting for 30 minutes. With implementation of CCPT, both children decreased in irritability and hyperactivity behaviours, with 100% of nonoverlapping data analysis indicating a strong effect size. This indicates that CCPT was very effective in reducing problematic behaviours for children with intellectual disabilty.

These randomised controlled outcome and single-subject studies of play therapy demonstrated the possible effectiveness of play therapy, especially CCPT, on child behavioural problems. While these studies were sound in methodology, additional similar studies with methodologically sound designs are needed to further justify the effectiveness of

specific play therapy models on children with defined behavioural problems. For instance, more randomised controlled outcome studies are needed to strengthen evidence as to its effectiveness. In addition, more single-subject and case studies are needed to delineate the process of change in play therapy and help illuminate how and perhaps why change occurs. Until then, the effectiveness of play therapy for child behavioural problems and how it works to produce positive gains remain unclear.

Relationship-Oriented Parent Intervention

Relationship-based interventions included FT, CPRT and other models of FT. The concept of FT in using parents to address their child's emotional disturbances was initiated by Bernard Geurney more than half a century ago. It was first introduced as a parent coaching approach conducted by a therapist, in response to the insufficiency of child interventions at the time (B. Guerney, 1964; B. Guerney et al., 1966; Rennie & Landreth, 2000). The distinction between FT and behavioural parent training (BPT) is grounded in the difference in the theoretical underpinnings and conceptions of child behavioural problems. For example, the behavioural theorists believed that a parent's actions, before and after child behaviour (antecedents and consequences) are the most important factors associated with an escape-avoidance trap between the parent and child, which either increase, decrease or maintain child behavioural problems. While Bernard Guerney (1964) proposed that the emotional warmth of the relationship between the parent and the child, such as unconditional positive regard for the child's expression, namely the therapeutic relationship, was the most important factor affecting child behaviours.

Consistent with the key principle of a child-centred framework, FT focuses on the quality of the parent-child relationship as the central therapeutic element in the therapy. The focus on relationship is fundamental in FT, and thus distinguishes it from BPT that targets a parent's and a child's problematic behaviours. Owing to its principle, FT aims at establishing

a therapeutic parent-child relationship rather than altering the parent-child behavioural interchanges, as is the case in BPT. Within the therapeutic parent-child relationship, the child is expected to work through his or her emotional difficulties and develop his or her potential and moreover, regenerate more positive perceptions of his or her parent (B. Guerney, 1964), which are commonly presented in the form of well-adjusted behaviours. The collaborative relationship between the intervention provider and a parent is also emphasised in FT in achieving optimum intervention effects. Based on its strong emphasis on relationships, FT is commonly known as a form of relationship-orientated parent intervention (Johnson, Kent, & Leather, 2005).

In contrast to the play therapy, Bernard Gurney (1964) proposed that parents could be the 'therapists' for their child's issues, which is shared by BPT, if sufficient guidance in building a therapeutic relationship between parent and child was systematically provided. In the context of FT, parents are used to replace play therapists in intervening in their children's issues based on two rationales. First, a parent interacts more frequently with his or her child than a therapist and thus could implement skills regularly (B. Guerney, 1964). Second, "the parent has more emotional significance to the child" (B. Guerney et al., 1966, p. 8), therefore "a relatively small amount of affection, attention, interest, etc., from the parent directly, can be expected to be more therapeutic for the child than a large amount of affection and attention from a therapist or a parent surrogate…; the child should therefore proceed to lift repression and work through his or her conflict more quickly" (B. Guerney, 1964, p. 308).

Filial therapy integrated the theory of person-centred therapy (Rogers, 1951) and the concept of CCPT (Axline, 1947). Bernard Guerney (1964) acknowledged that his invention of FT was influenced by the works of some early psychologists, including Freud, Moustakas and Rogers, who encouraged the use of play as an approach for parents to address their child's issues, such as phobia and toilet-training problems.

According to Bernard Guerney (1964):

With young children living with their families, the primary source of maladjustment can presumably be traced directly and indirectly to interpersonal relationships, past and present, within the family, and to the pattern of deprivation, conflict, and defence that these relationships have engendered. (p. 307)

For instance, a child could deny and distort his or her needs and feelings within the current as well as past negative interpersonal experiences in the family. The child's distortions would increase conflict and defensiveness within the child, which would be expressed in the form of maladjusted behaviours. Bernard Guerney and colleagues (1966) believed that maladjusted children are those who restrict their emotions due to the over-learned inhibitions on behaviour, or those who express their emotions in a form of destructive action due to the under-learned restriction on expression. This conceptual understanding of maladjustment in young children determines the focus of FT and thus makes the parent-child relationship the target of FT.

Within the therapeutic parent-child relationship initiated by the parent through the special home play sessions (SHPS), the child is expected to work through his or her emotional difficulties and develop his or her potential and moreover, regenerate more positive perceptions of his or her parent (B. Guerney, 1964). It aims to (a) "help the child change his perceptions or misperceptions of the parent's feelings, attitudes, and behaviours; (b) allow the child – mainly through the medium of play – to communicate thoughts, needs, and feelings to his parents that he had previously kept from awareness, thereby helping to resolve anxiety-producing internalised conflicts; and (c) bring the child a greater feeling of self-respect, self-worth and confidence" (Andronico & Guerney, 1967, p. 2). Parents are taught to master the "therapeutic and growth-enhancing attitudes" (L. Guerney & Guerney,

1987, p. 612), namely genuineness, empathetic understanding, and unconditional positive regard as aforementioned (p. 24) that are derived from person-centred therapy (Rogers, 1951, 1961). These attitudes represented in verbal and non-verbal responses, such as attentiveness, following the child's lead and reflecting the child's behaviour and emotion, are taught to parents to enable them to conduct CCPT (Axline, 1947, 1969) with their children at home, which is referred to as the special home play session (SHPS), in order to create the therapeutic conditions to achieve the above goals.

For example, parents are taught to embrace and convey the new attitudes to their children during the SHPS, which is child-centred in nature. By getting down to the child's levels of communication, the parent allows the child to use play, which is a form of expression that is developmentally appropriate for a child (Axline, 1947, 1969) compared to verbal laungauge, to communicate his or her needs and feelings to the parent. Child-centred play sessions are a suitable situation for the parent to drop his or her effort in controlling the child, by following the child's lead, because there are not set goals or agendas for play. By conducting child-centred play sessions with the child, the parent learns to replace the parent-oriented interaction, which is typically directive and controlling, with child-oriented play interaction. Child-centred play sessions help the parent to better understand the child's repressed and distorted needs, such as "My mother needs to give all her love only to me", "I do not need the love from my mother", or "I wish I had no sibling, thus I would be loved by my mother", and thus accept them and reflect them back to the child. This new dynamic between the parent and child helps the child to change his or her negative perceptions of the parent's feelings, attitudes and behaviours, as not loving, not responsive and not caring to more positive ones, such as loving, responsive and caring and to accept his or her need for love without distortion or repression. When the child's need for maternal love matches his or her perceived experience of being cared for and loved by his or her mother, the child is no

longer having an internalised conflict. Therefore, the corresponding anxiety of being unloved by his or her mother would have diminished, if not disappeared, and the child is, in fact, in a genuine state of self, which is stable and healthy. During this state, the child would obtain an increased sense of self-confidence and positive self-regard and thus show more significant and positive changes in attitudes and behaviours (Rogers, 1961).

The change in the parental attitudes is embedded through the use of CCPT principles and strategies to improve the child-parent relationship, which is therapeutic for constructive changes in the child. Therefore, parents are taught to use the basic CCPT strategies, such as behavioural tracking and reflection of feelings, as aforementioned (p. 25) with their children. These strategies teach parents to follow the child's lead is about teaching the parent to recognise and adapt to the child's desires and emotions, to see the child through the child's frame of reference as well as acknowledging and respecting, first within the context of play and then, hopefully, they will be able to improve their overall relationship by replacing the controlling directive interaction with more understanding, acceptance, respectful and equal ones.

Parents are also taught to set therapeutic limits on their children's destructive acts, as in CCPT, as a corrective response to the child's under-learned inhibition on expression (B. Guerney, 1964; B. Guerney et al., 1966). Unlike the behavioural and social learning theories that teach parents to use an antecedent behaviour (instruction) paired with a consequence (ignoring, time out or positive reinforcement) contingent on the child problematic behaviour, limit setting in play therapy and filial therapy encourages children to express themselves symbolically. Through limit setting, the parent teaches the child to use symbolic expression, through words, writing, painting, play and non-verbal gestures (Ginott & Lebo, 1961), as an alternative expression of feelings or reaction towards a particular stimulus. While all kinds of emotions and words are being accepted, socially undesirable behaviour, which is destructive

in nature, is not permitted during play sessions or outside of the play sessions. An example of limit-setting was provided in the previous section (p. 26).

The parents are asked to play with their child once each week. Then, when they meet with the therapist, the play sessions are discussed. To help parents strengthen their relationship with the child, the therapist explains things to them, models playing with them, reviews videos with them, and discusses issues that the parents bring to the session. The parents are asked to practise the strategies through SHPSs with their child on a weekly basis, when supervision and group discussion are provided. The intervention activities include didactic, skills practice, observation, group discussion, and feedback. The SHPSs are delivered by the parent(s) at a specific time and on a regular basis. They are aimed to train parents to engage their children in child-directed play and problem-solving, in order to help their children to attain positive self-regard and self-directed growth. As a result, the child would be motivated to work through his or her problems by correcting his or her distorted perceptions of others, particularly the parent(s). In the context of FT, parents' intentional attention to the child and the child's needs is therapeutic for the child and thus would 'lead to an increased sense of security, improved self-concept and a reduction of hostility on the part of the child' (B. Guerney, 1964, p. 308).

Models of filial therapy. In the 1990s, a number of scholars initiated the second wave of movement in developing FT. Consequently, several models of FT which are different from Guerney's group-based filial therapy (GGFT), in terms of the format of delivery, such as Vanfleet's individual filial therapy (VIFT) (Topham & VanFleet, 2011), and intervention duration, such as a 10-session group model, Landreth's filial therapy (LFT) (Landreth, 2002), which is known as child-parent relationship therapy (CPRT) later (Bratton et al., 2006), were developed.

Guerney's group-based filial therapy. Guerney's group-based filial therapy, which is later known as child relationship enhancement therapy, involves training parents of young children with emotional difficulties, who are under the age of ten years. The parents, in a group of six to eight, attend weekly meetings for approximately six to eight months (B. Guerney, 1964). The parents learn to take on the role of a client-centred play therapist by conducting SHPSs with their own children to convey the "three attitudes" of person-centred therapists, namely genuineness, empathetic understanding and unconditional positive regard, to their children (Andronico & Guerney, 1967).

Guerney's group-based filial therapy (B. Guerney, 1964) consists of three stages. The first part of Stage 1 involves explaining the benefit of FT for the parent and the child and for parent-child relationships. The medium and specific techniques to achieve it within defined limits on destructive behaviour are also discussed. In contrast to an instructional approach, the parent's feelings and reactions are the focus of the discussion. Basic CCPT strategies, including structuring, restatement of the contents and clarification of feelings of the child, are taught to the parents. In the second part of Stage 1, the therapist demonstrates the child-centred play sessions with non-clinic children and the children of the parents in the group in the clinic. Subsequently, the parents are required to practise their session role with their own child, under therapist supervision, and followed by discussion.

Stage 2 begins, usually after six to eight sessions, when the parents are ready to start their special home play sessions (SHPSs) using the standard play therapy materials. The parents are required to take notes of each SHPS and record the sessions when possible. In group meetings, the therapist reviews and discusses the video-tapes and notes taken by the parent during SHPSs. During the group discussion, the parents' and the child's emotions and reactions in the SHPSs are highlighted along with session role and play therapy techniques. Stage 3 is a termination-of-therapy stage. The length of therapy varies among parents in the

group. With the guidance from the therapist, parents evaluate their own therapy success individually and thus determine their termination voluntarily.

Table 1

Summary of Guerney's Group-Based Filial Therapy Research on Child Behavioural or Emotional Difficulties

Studies	Population & Characteristics	Sample size	Research design	Measures	Findings
Stover & Guerney, 1967	Mothers of children (5.5-10-years-old) with emotional difficulties	28 mother-child dyads	2 Wait-list controlled groups	Observation	Mothers' reflective behaviours ↑ 15% & 58%. Mothers' directive behaviours ↓ 62% & 29%
Sywulak, 1978	2- to 10-year-old children with behavioural or emotional difficulties	32 parents from 19 family units	Single-case with a 4-month control period	PPAS; Parent checklists & rating scale of child adjustment; Interviews	↑ parent acceptance; ↓ child behavioural problems.
Sensue, 1981	2- to 10-year-old children with behavioural or emotional difficulties	38 family units	Time-series, group comparison	PPAS; Parent checklists & rating scale of child adjustment; Interviews.	Parents in the GFT maintained their gains in parent acceptance; Children in the GFT maintained their gains in behavioural problems.
Jonson-Clark, 1996	Preschool boys; oppositional or conduct disorders	57 parent-child dyads	Randomised groups controlled	ECBI	↓ child behavioural problems at post-intervention and at 2-month follow-up.
Guerney & Flumen, 1970	Withdrawn pupils (grade 1, 2, 3 and 5)	15 teachers -child dyads	Randomised groups controlled	Observation	↑ average assertiveness scores.

Note. ↓ = reduce; ↑ = increase.

In 1964, Bernand Guerney carried out his first exploratory study to investigate the outcomes of training parents to conduct weekly home-play sessions for eight to ten months with their children who exhibited emotional disturbance. The observational data indicated some positive outcomes, particularly on children's fantasy and the parent-child relationship. The positive findings convinced Guerney to further investigate the utility of the approach as a valuable parent intervention. Subsequent to a series of experimental studies conducted in the 1960s and 1970s (e.g., Andronico & Guerney, 1967; B. Guerney & Flumen, 1970; Stover & Guerney, 1967), as summarised in Table 1, Bernard Guerney and his colleagues introduced FT as a new approach to address children's emotional difficulties.

Following initial exploratory studies of the procedures of FT, Stover and Guerney (1967) conducted a controlled outcome study of GGFT for mothers of children with emotional difficulties. A total of 28 emotionally maladjusted children, aged between five and 10 years, and their mothers were assigned to one of two wait-list control groups or one of two experimental groups. Mothers in the experimental groups received ten 90-minute sessions of discussion, observation and practice, including three to five live demonstrations of CCPT by the psychologist with non-clinic children and three parents' practice of play sessions with their own children. The parent's and the child's behaviours in play sessions were recorded and coded to determine the treatment outcomes. The findings at post-intervention showed that GGFT improved parent-child interactions by altering mothers' behaviours, such as increasing mothers' reflective behaviours by 15% and 58%, and decreasing mothers' directive behaviours toward their children by 62% and 29%, in two of the experimental groups respectively. However, no significant improvement was observed, including verbal leadership and verbal dependency dimensions, across children and across different conditions. In terms of emotional expression, the authors concluded that the magnitude of change in mothers' behaviours was positively reflected in their children's behaviours, even in the early

phase of the intervention. However, the specific changes in child behaviour did not present in the studies.

Extended from the works of Bernand Guerney and colleagues on FT, Sywulak (1978) endeavored to investigate the effects of GGFT on parental acceptance and child adjustment. A total of 27 families (19 mothers and 13 fathers), of children aged between 2 and 10 years with behavioural or emotional difficulties were recruited, while 19 of them completed the intervention and all the measures, including the *Porter Parental Acceptance Scale* (PPAS), a rating scale and checklists of child adjustment. All families completed a 4-month baseline non-treatment control period, to serve as their own control data, prior to the beginning of the intervention, which ranged from six to 10 months. All families were reassessed with the same measures prior to the beginning of the intervention, at the second, Phase I-didactic skills training, and again at the fourth months of the intervention, Phase II-home play sessions and group supervision.

During baseline, there was no significant change in either the parental acceptance or child behaviour. Once GGFT was started, there was an overall gain in parental acceptance by the fourth month of the GGFT; 70% of the gain, which is significant, occurred in the first two months of the GGFT. For child adjustment, the findings indicated that all children reduced their behavioural problems, which included aggressive, emotional and withdrawn dimensions, by at least 50% at the second and the fourth months of GGFT. The significant improvement in parental acceptance implied that the parents might have utilised the principles they learned through didactic, demonstration and practice play sessions with their children, which might have accounted for the speedy and significant improvement in child behavioural problems at the early stage of the GGFT. This study provided some important findings regarding the effects of different intervention phases of GGFT on children and their parents; however, without the Phase III-skill generalisation, post-intervention and follow-up data, its outcomes

may have limited importance. Moreover, owing to the fact that parents were the intervention recipients and the only assessors of the intervention effects, the attempt to generalise the findings might be affected.

Later, Sensue (1981) aimed to determine the short and long-term follow-up effects of GGFT on children with behavioural and emotional difficulties and their parents. The author recruited all the dyads, who participated in Sywulak's (1978) study and 19 families who presented with characteristics similar to the original families in Sywulak's study to participate in a 3-year follow-up study. All families were assessed with the same measures used in Sywulak's study at the sixth month of the intervention and three years after the completion of GGFT. The findings indicated that the gain in parental acceptance obtained in the fourth month of GGFT maintained up to three years. In addition, all GGFT parents reported that the gains in their children's behaviours made during the treatment were maintained at the 3-year follow-up. These findings supported the principle of FT, which is that "parental acceptance is intricately related to adequate child adjustment" (Sensue, 1981, p. 116).

VanFleet, Ryan and Smith (2005) indicated that Johnson-Clark's study, an unpublished dissertation, "is the best-design empirical study of filial therapy to date". In that study (Johnson-Clark, 1996 in VanFleet et al., 2005) , 57 mothers of children aged between three and five years of age with conduct problems were recruited. All mothers were randomly assigned to a FT experimental group, an attention-only control-group, where the mothers were asked to provide 30-minute weekly play sessions with their child, or a no-treatment control-group. Of these, 52 of them completed the intervention and all the required assessments. Mothers in all three groups reported decreases in their child's conduct problems, on the ECBI, immediately after the intervention phase. However, only children in the experimental group continued to decrease in their conduct problems at the 2-month

follow-up and the majority of them had so decreased in behavioural problems that they were no longer meeting the clinical cut-off score for behavioural problems.

Studies have suggested that GGFT is effective in changing maternal attitudes by empowering mothers to respond to the conflict between them and their children positively. The increase in mothers' positive parenting attitudes was found to reduce the level of conflict between mother-child dyads, which in turn, improved the child's self-concept (Andronico & Guerney, 1967) and child behaviour (Rennie & Landreth, 2000; VanFleet et al., 2005), which ultimately increased the levels of mothers' acceptance towards their children (L. Guerney & B. Guerney, 1987) problems The positive findings of GGFT as a parent-child intervention in these early studies have encouraged the development of FT with continuing research (VanFleet et al., 2005).

Landreth's filial therapy or child-parent relationship therapy. In the early 1990s, Garry Landreth restructured GFT into a time-limited 10-session programme, namely Landreth's Filial Therapy (Landreth, 1991), which was then published in the form of a manual, which is known as Child-Parent Relationship Therapy (Bratton, Landreth, Kellam, & Blackard, 2006). As a relationship-focused intervention, CPRT emphasises the therapeutic bond in every involved relationship, including the parent-therapist relationship, the parent-parent relationship and the parent-child relationship. In contrast to BPT, CPRT encourages parents to focus on their own strengths and their children's potential rather than on problematic parent and child behaviours.

Child-parent relationship therapy comprises ten modules, which are normally delivered over 10 two-hour group sessions by one or two trained providers. Parents, in a group of eight to 10, attend the sessions on a weekly basis. Consistent with FT, the goal of CPRT is to improve the parent-child relationship through weekly parent-child SHPS. It aims to help parent to reveal their child's inherent tendency for being constructive, through achieving

healthy regulation, autonomy, independence, and sufficiency (Landreth, 2002). The change in the child's maladjustment is considered to be a byproduct of the improved relationship and the positive self-concept on the part of the child.

To achieve its goal in establishing a therapeutic parent-child relationship, advanced CCPT strategies, such as choice-giving and esteem-building, are taught in addition to the basic CCPT strategies (Bratton, Landreth, Kellam, & Blackard, 2006). To help parents learn the strategies, the group leader(s) explains the principle of each strategy to them, practises the strategies with them using role-play, reviews videos of child-centred play sessions with them, and discusses issues that the parents bring to the session. The parents are asked to make notes for each of their weekly SHPS and video-record some of the SHPSs, which would be discussed during group sessions, where supervision and feedback are provided by the group leader(s).

In a review of FT studies, Rennie and Landreth (2000) indicated that FT has been implemented with a range of parent populations, including those from different nationalities, to address a specific child issue, for example chronic illness and learning difficulties. The authors reviewed a selection of experimental research studies of FT dating from 1965 to 1999. The studies were selected if they utilised standardised measures or rating scales to determine the effects of GGFT or LFT. The review indicated that parents who participated in FT obtained a significant increase in parental empathy as measured by the *Adult-Child Interaction Scale* (MEACI) (B. Guerney et al., 1968) and parental acceptance of their child as measured by the PPAS (B. Porter, 1954), whereas a significant reduction was found in parental stress as measured by the PSI (Abidin, 1983) as compared to their counterparts.

Rennie and Landreth's (2000) review suggested that the children whose parents received FT improved in their behaviour problems and self-esteem as measured by a range of standardised measures, including the early version of the ECBI and the *Joseph Preschool and*

Primary Self-Concept Screening Test (JSCS), as compared to their own pre-test scores and to the post-test scores of those in the control groups. Meanwhile, the children whose parents received FT have significant increases in their desirable play behaviour, self-directedness and connectedness with their parents as compared to those in the control group, as measured by the adapted version of the parent rating form of *Children's Play Behaviour*, in the context of a control outcome study. The findings of this review suggested that FT could be beneficial for different parent populations, of children demonstrating a range of issues and difficulties.

However, the authors indicated that more studies are needed to clarify the effects of FT on specific parental and child adjustments and outcomes. Further studies in FT should also include observational data or third-party reports in assessing its effectiveness, as most of the studies in this review relied highly on parent-reports. This review included studies that investigated two different forms of FT, which are diverse in the length of training time, ranging from 10 weeks to four months; therefore the effectiveness of a specific form of FT on parents and their children is undetermined. In order to advance our understanding of the benefit of FT, it would be useful to explore the outcomes of specific treatment duration and intervention components on parental and child behaviours, in further studies.

Child-parent relationship therapy is relatively new as compared to other forms of FT. However, it has been well-researched and its effectiveness has been established in more than 40 studies (Bratton, Landreth, & Lin, 2010). By saying that, most of the related studies focused on its effectiveness with different parent populations instead of specific child issues, particularly lack of research on child behavioural problems. To date, a few studies have been found to report the outcomes of LFT or CPRT on children with disruptive behaviour (e.g., Athanasiou & Gunning, 1999; Boyer, 2011; Moses, 2013), as summarised in Table 2.

In Athanasiou and Gunning's (1999) study, four mothers of children with behavioural problems, such as non-compliance, fire setting and temper-tantrums, were recruited from a

preschool. Two mothers attended the 10-week LFT and completed all the inventories. The child and parent outcomes were measured by the *Behavior Assessment System for Children-Parent Report Form* (BAS) and the PSI, respectively. In addition, the parents' perceptions of the LFT process and its effectiveness were explored through the mothers' verbal reports during and following the intervention. The findings showed that parent-report of Child 1's externalizing and internalising problems reduced from clinical to non-clinical levels immediately after the intervention and these improvements were maintained at 2-month follow-up. However, no significant change was found in parent-report of Child 2's externalizing and internalising problems immediately after the intervention, as compared to his low initial scores at baseline. At the 6-month follow-up, both mothers reported an improvement in the parent-child relationship and their self-confidence in parenting. This resulted in a reduction in their child's behavioural problems at home and at preschool, while an increment was perceived in their child's verbal expressions. The changes in the mothers' scores on the PSI were consistent with the changes on their child's behaviour. However, only Child 1 showed changes in behaviour as measured by the mother on BAS.

Table 2

Summary of Child-Parent Relationship Therapy Research on Child Behavioural Problems

Studies	Population & Characteristics	Sample size	Research design	Measures	Findings
Athansious & Gunning, 1999	Children with behavioural problems.	2 mother-child dyads	Case study	BAS; PSI	Child 1, ↓ behaviour problems; Mother 1, ↓ stress; No change in Mother 2 and Child 2.
Boyer, 2011	A 4-year-old with behavioural problems.	1 care giver-child dyads	Case study	MIM	↓ child aggression; ↓ stress in caregiver.
Moses, 2013	Children (3.5-9 years) with disruptive behaviour	10 parent-child dyads	Multiple-baseline single-subject study	ECBI; CBCL; FPC; PRQ; PPAS; PSI MEACI; DPICS	↓ child disruptive behaviour (parent reports); ↓ parenting stress; ↑ parental empathy; ↑ positive parental behaviour; ↑ observed child negative behaviour.
Kidron & Landreth, 2010	Kindergarten and elementary school-aged children	27 parent-child dyads	Controlled-outcome	CBCL; PSI; MEACI	↓ externalising; behaviour problems ↓ parenting stress; ↑ parental empathy.
Smith & Landreth, 2003	Victims of domestic violence & their children (4-10 years)	14 parent-child dyads for intensive LFT	Groups comparison (alternative & non-treatment control)	CBCL; JSCS; MEACI	Children and their parents in the experimental group improved significantly in all measures.

Note. ↓ = reduce; ↑ = increase.

In a recent case study, Boyer (2011) documented the process and the progress of CPRT with a retired grandfather and his 4-year-old grandson, who was under his custody. The child was referred for therapy by the Protective Care Services, due to his non-compliance, temper-tantrums, aggression and separation anxiety, at preschool and at home. Boyer (2011) used qualitative data, through observed interactions of the dyad and verbal reports of the

grandfather, to capture the progress made by the dyad in the process of CPRT. Prior to the CPRT, the grandfather attended a 2.5-hour intake meeting and had an interaction session with his grandson, using the *Marschak Interaction Method*, which was observed and video-taped by the therapist. Following that, the therapist developed treatment goals and a treatment plan together with the grandfather. The treatment goals were to help the child to (a) identify, (b) manage, and (c) express his emotions appropriately. Subsequently, the grandfather received a 10-session CPRT, twice a week, in five consecutive weeks. However, the duration for each session was not stated in the article. The therapist supplemented the verbal didactic aspects of the first five sessions with visual elements, including training videos, play therapy videos and demonstration.

In the first week of training, the grandfather expressed his confidence toward the programme. In the following week, he was pleased that he learned to give undivided attention to his grandson for thirty seconds, and he felt that this made his grandson feel better. In Week 3, he reported that his reflection of his grandson's feelings helped his grandson to identify and manage his anger. In Week 4, he was glad that the special playtimes helped in diffusing his grandson's anger and aggression, and in regulating his negative emotions, inside and outside of the special playtimes. In the final week, the grandfather was pleased that he learned to use limit-setting, and he felt that this helped his grandson respect and accept the limits on his behaviour, while helping himself feel less stressed with his grandson.

In one of the latest CPRT studies, Moses (2013) aimed to address the limitations of CPRT research to examine the impact of the 10-session CPRT. A multiple-baseline across participants design was used in this study. Ten parents of children, aged between 39 months to 105 months, with disruptive behaviour, enrolled in the study. The parents who were eligible to participate in this study (a) were not participating in any other therapy for themselves or for their children over the course of the study, (b) had a child who scored

above 130 on the ECBI intensity score, and the child (c) was not taking any psychotropic medication, (d) had no prior diagnoses of autism spectrum disorder, intellectual disability, or major sensory impairment.

During the pre-intervention assessment session, the ECBI, the CBCL, the *Filial Problem Checklist* (FPC), *Parenting Relationship Questionnaire* (PRQ), PPAS and *Parenting Stress Index-Short Form* (PSI-SF) were administered (Moses, 2013). Moreover, a 20-minute individual parent-child play session was video-recorded and was scored using the MEACI and *Dyadic Parent-Child Interaction Coding System* (DPICS). Following the pre-therapy assessment, each parent was randomly assigned to either three or five weeks of baseline assessment, followed by six weeks of therapy. The ECBI was administrated by telephone prior to each weekly assessment or treatment session. The treatment consisted of six weekly 90-120 minutes individual sessions with the parent. The parent was required to conduct and video-record seven 30-minute play sessions at home with the child, beginning following the second intervention session. Supervision during the sessions was based on a discussion of the videos. For post-therapy assessment, one week following the conclusion of the intervention, the *Client Satisfaction Questionnaire*, a *Play Session Follow-up Questionnaire* and all pre-therapy measures were again administered. At one month follow-up, all the post-therapy measures were administered again, excluding the CRS and the observational measures.

Seven out of 10 parents and their children completed the treatment, while only three parent-child dyads completed the follow-up measures (Moses, 2013). The findings indicated an improvement in child behavioural problems as measured by the ECBI, CBCL and FPC. All seven children were in the clinical range in their ECBI intensity scores at baseline, while six out of seven of them reached the normative range at post-intervention. Three children, who provided follow-up data, continued to decrease in their ECBI intensity cores. In

addition, following intervention, most of the children scored below the clinical range on all the CBCL scales. As for the parents, four out of seven of them who improved in parenting stress moved from clinical to normative range at post-intervention.

The findings of the observational data of parent-child play interactions indicated that most of the parents improved in positive parent behaviour (Moses, 2013). All parents improved in their acceptance and involvement, while five out of seven of them improved in allowing the child self-direction as measured by the MEACI. The findings on the DPICS indicated a substantial improvement was made by all parents in reducing their use of commands; only one parent gave one command to the child at post-intervention. Furthermore, five parents improved in their positive behaviours, with an average increment of 4 to 5 times per 5-minutes in behavioural descriptions and reflections. However, after a closer inspection of the data, the profound increment in positive behaviour made by all parents in the early sessions, except one, was found to reduce progressively over the course of the play sessions. Regardless of all parental improvements, a slight increase in child negative talk, yelling and whining, from an average of 0.29 to 0.43 per 5-minute, was observed.

In the recent decades, some FT researchers have focused on investigating the effects of intensive FT on parents and their children (e.g., Kidron & Landreth, 2010; Smith & Landreth, 2003). In Kidron and Landreth's study (2010), 27 parents whose children aged between 2 and 10 years, recruited through kindergartens, primary schools and community centres, were assigned to an experimental group or a non-treatment control-group. Parents in the experimental group received an intensive version of the 10-session CPRT in five weeks; they attended two CPRT sessions each week. Parents in the non-treatment comparison group attended a 3-hour parenting training at the conclusion of the study, after post-test. The outcomes were measured by two standard inventories, the CBCL and the PSI, and video

observation of 15-minute playtimes at pre- and post-intervention, which were coded using the MEACI. Effect size was measured by eta-square.

The findings indicated large gains in parental outcomes, especially in parental empathy as measured by the MEACI (Kidron & Landreth, 2010). The parents in the experimental group scored significantly higher than those in the control group on communication of acceptance, allowing the child self-direction, with a medium to large effect size of 0.79, 0.91, respectively, but a small effect size of 0.37 on parent involvement. The findings implied that parents are able to develop understanding of how to improve their relationship through CPRT. The parents in the experimental group decreased in parental stress in parent and child domains, with a small effect size of 0.37 and 0.20, respectively. Despite all the parental improvements, the effect of the intensive filial therapy on child outcome was limited. The children in the experimental group decreased in externalizing problems, with a small effect size of 0.17. However, no significant differences were found between groups in child total behavioural problems and internalizing problems.

In Smith and Landreth's study (2003), 14 victims of domestic violence were recruited from a domestic violence and a homeless shelter to participate in the study with one of their children aged between 4 and 10 years, who had witnessed the violence and presented with behavioural problems. Thirty- two children acted as comparisons. These were participants in two other parent training studies (Kot et al., 1998; Tyndall-Lind et al., 2001 in Smith & Landreth, 2003), including 10 children who had received an intensive sibling group play therapy (SGPT), 11 children who had completed an intensive individual play therapy (IPT) and 11 children who had received no intervention. The outcomes were measured by the CBCL, the JSCS and the MEACI.

The parents in the experimental group received an intensive version of the 10-session LFT in five weeks; they attended two sessions each week in a small group of three to four

mothers. Other than the differences in treatment intensity and duration, several adaptations were made to the LFT in Smith and Landreth's (2003) study. Each session comprised brief instructional components and a parent-child practice session and followed by a parent-child play session lasts between 30 and 40 minutes. Live demonstrations and direct supervision were provided to each mother during group meetings. A mini-demonstration of a10- to 15-minute play session by the facilitator with the child was video-recorded and viewed by the absent mother the following day.

A total of 11 mothers completed the intensive LFT. The post-intervention findings indicated that children in the intensive LFT group improved significantly on all measures, including CBCL and JCSC, as compared to those in the non-treatment comparison group (Smith & Landreth, 2003). Children in all treatment groups, intensive LFT, intensive IPT and intensive SGPT, were equally improved in their CBCL scores on *Total Behaviour Problems* and *Externalizing Behaviour* as compared to those in the non-treatment group. However, only children in the intensive LFT group improved significantly in their CBCL subscale scores on *Internalizing Behaviour* as compared to those in the non-treatment group. The mothers in the intensive LFT improved significantly in empathy, communication of acceptance and allowing the child self-direction. However, children in the intensive IPT improved more significantly in self-concept than children in the intensive LFT and the intensive SGPT groups.

In general, the above studies indicate CPRT or LFT is an effective intervention in improving parental empathy and reducing parenting stress, parent-reported child problematic behaviour and child self-concept. However, objective measures of child behaviour, such as direct observation, have not been used in the above studies. Owing to several limitations in the above studies, particularly in methodology, these findings must be considered with caution. Studies of CPRT, generally are characterised with poor design, are narrative in

nature (e.g., Boyer, 2011), have a small sample size (e.g., Athanasiou & Gunning, 1999), lack standard and viable measures (e.g., Boyer, 2011), and lack long-term follow-up data (e.g., Athanasiou & Gunning, 1999; Boyer, 2011; Moses, 2013; Smith & Landreth, 2003). Studies with strong and sound methodology and designs are needed to determine the outcomes of CPRT on specified child or parent populations. For instance, randomised-controlled assignments, multiple-baseline single-subject designs, control or comparison conditions can be used in future studies to establish the efficacy of CPRT. Further studies of CPRT may also include standardised and reliable measures of behaviour, such as ECBI. Additionally, third party reports, such as a teacher's report, behavioural diary of child behaviour and coding systems, such as DPICS, could be included to reveal important yet objective information regarding the changes made by the dyads over the course of the intervention.

VanFleet's Individual Filial Therapy. Rise VanFleet reformed GGFT into an individual family therapy for parents of two- to 12-years-old children. This involves training parents to carry out 30-minute non-directive home-play sessions with their children individually on a weekly basis. To do this, parents are trained in four specific skills namely structuring, empathic listening, child-centred imaginary play and limit-setting. The parent-therapist relationship during the training sessions and the parent-child relationship established through the non-directive play sessions are based on the concepts of CCPT. It is important for the therapists to apply the principles of CCPT in sessions with parents in order to create a platform for the parents to express and discuss their concerns and emotions non-defensively (Topham & VanFleet, 2011).

Similarly to GGFT, VIFT consists of three phases. Phase 1 comprises informational and educational sessions. In this phase, the goals of filial and play therapies are explained, followed by learning and practising the four specific strategies through role-play. During Phase 2, the therapist observes and gives feedback to the parents(s) on the non-directive

parent-child play sessions carried out in the training setting. If both parents are participating in VIFT, they are each asked to play with the child in a non-directive manner, to observe each other's play sessions, and to discuss these with the therapist. Phase 3 begins, usually after the parents become confident with the strategies, with the parent(s) conducting the weekly play sessions at home with the child. The parent(s) are encouraged to record the home play sessions and complete a reflection form for each session for discussion and feedback. Discussion and feedback are focused on the parent(s)' concerns and challenges in being nondirective in a dynamic fashion. In the meantime, the therapist helps the parent(s) to generalise the skills into their daily living (Topham & VanFleet, 2011).

Table 3

Summary of VanFleet's Individual Filial Therapy Research

Studies	Population & Characteristics	Sample size	Research design	Measures	Findings
Grskovis & Geotze, 2008	Mother with parental stress	2 mother-child dyads	Active control group comparison	CBCL; Observation	↓ child internalising & total behavioural problems; ↑ using creative media, testing limits. ↓ asking questions & exploring behaviour. ↑ parent reflective responses.
Topham, Wampler, Titus & Rolling, 2011	Parent of a 2- to 10-year-old child	27-parent-child dyads	Pre-post	BSI; ECBI; PMEI; PPAS MEACI	↑ parental acceptance and/ or parenting stress related to the ↓ in child behavioural problems.

Note. ↓ = reduce; ↑ = increase.

In this section, two studies which assessed the VIFT effects on parents of young children with behavioural problems, as summarised in Table 3, were discussed. The outcomes of a brief VIFT intervention were assessed using a pre-post control group design

among 33 German mothers and their children (Grskovic & Goetze, 2008). The mothers were referred from a social agency for treatment as they were experiencing a wide range of parental stress from physical and psychosomatic to psychological. Prior to the 2-week training programme, mothers in the VIFT condition received two 90-minute sessions to learn four basic skills: orienting the child, active listening, how to play with the child, and limit-setting. During the two-week of training, the mothers were encouraged to have no fewer than five play sessions with their children. Over the training phase, the mothers attended a total of six group discussion sessions and two individual feedback sessions. Mothers in the control group participated in the usual treatment covered by the health insurance system, known as the Mother Child Cure Program. It treats the mothers and the children separately. The mothers attended individual counselling sessions and group sessions for planned social activities, while the children were involved in supervised activities.

The behaviours of the children in both groups were assessed through mother-report on the CBCL before and after the training. Mother-child interactions, in the first and last 30-minute video-recorded play sessions, were rated and assessed. Mothers' reflections on the child's actions, verbal statements and feelings, mother's acceptance of the child and empathy with the child were coded. To determine the presence of the primary variables of the play therapy process, the type of actions initiated by the child included exploring, asking questions, using creative media and testing limits. At post-treatment, the mean *Total Behaviour* and *Internalising* scores on CBCL of the children in the VIFT condition reduced significantly as compared to the pre-treatment scores, which were above the clinical cut-off. The three categories of the mother's reflection increased significantly in the last video-recorded play session as compared to the first. The observation data showed that the children in the VIFT condition increased in the use of creative-media and testing-limits and reduced in asking

questions and exploring in the last play session as compared to the first session (Grskovic & Goetze, 2008).

The findings suggested that the intensive two-week VIFT was sufficient in increasing reflective statements given by the mothers, thus resulting in a significant reduction in their perceived internalising and total behaviour problems in their children. The authors concluded that a parent-child play based intervention, even though delivered in a short timeframe, could produce significant reductions in children's difficult behaviours and improvement in mothers' use of play therapy skills (Grskovic & Goetze, 2008). This study, although it provided data on mothers and children's observed behaviours, is limited because the coded child's behaviours were not used to define intervention gains by the authors.

Topham, Wampler, Titus and Rolling (2011) explored parent and child factors which may predict the outcome of a 10-session adapted VIFT, using a pre-post research design. A total of 52 parents of children, aged between two and five years of age, were recruited and participated in the study. However, only the data of 27 parent-child dyads, who completed all sessions, were analysed. The adapted VIFT consisted of 4 didactic and demonstration sessions, three direct observations and supervision of 30-minute child-centred play sessions at the clinic and three sessions for skills generalisation. Each session was delivered on a weekly basis for an hour.

The pre-test mean-score of the child behaviour problems on ECBI was above the clinical cut-off (Topham et al., 2011). The greater decrease in child behavior problems at post-test was associated with parents' reports of higher levels of distress on the *Brief Symptom Inventory* and poorer child emotion regulation at pretest. On the other hand, the greater increment in parent acceptance, as measured by the PPAS, at post-test was related to the parents' self-reports of poorer regulation of emotion, as measured by the *Parent Meta-Emotion Interview*, at pre-test. Moreover, parents, who reported a lower level of social

support at pre-test, showed a greater improvement in communicating acceptance in the play session, as coded using the MEACI, at post-test.

The researchers suggested that the parents' and the child's self-regulation of emotions are the primary concern in FT, thus it could be an important mediator for treatment outcome, particularly in child behaviour and parent acceptance (Topham et al., 2011). The authors concluded that FT can be an effective intervention for parents with higher parental stress and poorer regulation of emotion as well as for parents of children with severe behaviour problems and poorer regulation of emotion. Despite all the positive findings, there were three aspects in this study that limited its conclusion and generalisation. First, there was a high dropout rate of 48%. Second, no follow-up data were available to establish its long-term effectiveness. Lastly, child outcome relied solely on parents' reports.

In summary, the three modalities of FT are grounded in person-centred theory by teaching parents to conduct play sessions with their own children, modelled after child-centred play therapy, in addressing their children's behavioural and emotional issues. However, there are some differences among them as summarised in Table 4 (p.60). First, the VIFT is conducted in an individual format, while the other two are delivered to a group of six to 10 parents. While they are all conducted on a weekly basis, only CPRT or LFT has a predetermined number of sessions, which is relatively fewer than the other models of FT. In terms of taught strategies, they all taught parents the basic child-centred play strategies, while some advanced play therapy strategies, including encouragement and esteem-building, and an additional strategy namely choice-giving strategies, are only taught in CPRT. In teaching the parents the strategies, GGFT and VIFT employed live demonstration of play sessions with non-clinic children and the focused children, respectively, while CPRT or LFT used video-clips of recorded play sessions.

Table 4

The Characteristic of the Different Models of Filial Therapy

Model	GGFT	VIFT	LFT / CPRT
Format	Group	Individual	Group
Participants	6-8 parents	1 or 2 parents	8-10 parents
Length per session	90 minutes	60 minutes	120 minutes
Frequency	Weekly	Weekly	Weekly
Duration	6-8 months	10 -20 sessions	10 sessions
Skills taught	Structuring, Restatement of the child's verbal contents, Clarification of the child's feelings, Limit-setting	Structuring, Empathic listening, Child-centred imaginary play, Limit-setting	Structuring, Be-With attitudes Behavioural tracking, Reflection of feelings, Limit-setting, Encouragement, Esteem building, Choice-giving strategies
Methods	Information & educational Live demonstration Practice of CCPT Video supervision Discussion	Information & educational Live demonstration Role-play Practice of CCPT Direct supervision Discussion	Information & educational Role-play Video demonstration Practice of CCPT Video supervision Discussion
Medium	Child-centred play	Child-centred play	Child-centred play

Note. GGFT=Geurney's group-based filial therapy, VIFT=VanFleet's individual filial therapy, LFT=Landreth's filial therapy, CPRT=Parent-child relationship therapy

Behavioural-Oriented Parent Intervention

Behavioural-oriented parent training has been rapidly and intensively studied since the 1970s (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013; L. Guerney, 2000; Topham et al., 2011). It is based on behavioural theory and aims to change parenting behaviours in order to reduce behavioural problems in young children (New Zealand Special Education Division, 2003; Thomas & Zimmer-Gembeck, 2007). It focuses on treating children's

externalising behavioural problems indirectly by intervening with their parents. Building on this notion, parents are treated as co-clients in behavioural oriented parent training models (Foote at al., 1998 in Johnson et al., 2005). For instance, the therapist intervenes to change parent behaviours which could then directly promote positive changes in child behaviour.

A number of BPTs designed to address behavioural problems in young children has been identified in an early report by the New Zealand Ministry of Education (2003). Among them are the Oregon model of parenting skills training, the Forehand and McMahon parenting skills training, the Webster-Stratton parenting skills programme, which is currently known as IY-PT, PCIT, and Triple P. Of these, both Oregon and IY models of parent training programme were categorised as a well-established intervention for antisocial children in the review by the Special Education Division of the New Zealand Ministry of Education (2003). However, the review indicated that Triple P and IY-PT have more advantages over other BPT interventions in the context of New Zealand, in terms of the clinical manuals' accessibility and training availability for non-professional providers in the form of video-facilitation.

All of the behavioural-oriented parent training models were either developed from the operant theory, social learning theory (Bandura & Walters, 1963) or the principles of the coercive family process (Patterson, 1982). These theories rest on the conceptualisation of behaviour as controlled by environmental events, which include parenting behaviours, which cause the child's behaviour to increase, decrease or maintain. Behavioural oriented parent training directly targets the system, parent-child coercive interchange, maintaining the child's behaviour problems. It involves training parents to disengage from coercive interchanges in the families (Comer et al., 2013) by implementing positive contingencies whenever their child's problematic behaviour takes place (Sanders & Dadds, 1982). Patterson and

colleagues (1982) suggested that a parent's behaviour can be altered by providing positive parenting skills training to the parent in order to modify the child's problematic behaviour.

The objectives of behavioural-oriented parent training on child behaviour are twofold. First, it aims to increase child positive behaviour. Second, it is targeted at reducing child behavioural problems. To accomplish both, two different sets of parenting strategies are developed. Parents are taught to use differential reinforcement strategies, including descriptive praise and incentives, to increase their children's pro-social behaviour, while child management strategies, including clear instructions, planned ignoring and time-out, are taught to parents to reduce child antisocial behaviour. Both sets of strategies help parents to generate positive contingencies to replace their coercive responses when interacting with their children on a daily basis.

Traditionally, behavioural-oriented parent training, such as the Oregon model of parenting skills training, has a greater focus on altering parent behaviours through behavioural modification than the parent-child relationship, which it considers as a nonspecific factor in behavioural therapy (Eyberg, 1988; Schaap, Bennun, Schindler, & Hoogduin, 1993). While positive reinforcement may improve the parent-child relationship, it is taught to parents as a technique to change their child's behaviour, but not as a technique to develop a warm, loving and emotional part of a relationship.

However, some behavioural researchers have recognised the parent-child relationship as a mediated factor that influences the implementation of behavioural strategies and promotion of child behavioural changes (Eyberg, 1988; Forehand & Kotchick, 2002). For instance, by integrating child-centred and behavioural techniques, Eyerbg (1988) incorporated the traditional play therapy techniques of Axline (1947) by emphasising on "the development of a warm and safe therapeutic relationship which allows the child to experiment with change" as an additional factor in her own therapy approach (p. 33). Adding

to that, Forehand and Kotchick (2002) reworded "reinforcement… as a step to build stronger parent-child relationships" when they were training parents in order to match the principle of reinforcement with specific parenting beliefs of the parents (p. 381).

Incredible Years-Parent Training and PCIT are commonly referred to as a form of behavioural-oriented parent training, owing to the components of social-learning theory. However, unlike other behavioural approaches, they both teach parents child-centred parent-child play techniques to improve the quality of parent-child interaction. For instance, PCIT emphasises "enhancing the quality of the parent-child relationship, which serves as the foundation for effective behaviour change" (Eyberg, 1988, p. 37), while IY-PT focuses on increasing 'positive exchange between parent and child to make parents more aware of their children's individuality' (Webster-Stratton, 1981, p. 96). In addition to the use of play as a mode of delivery, both PCIT and IY-PT integrate traditional play therapy techniques, including following the child's lead; not giving commands, asking questions or criticising; and behavioural tracking and reflection, with some behavioural techniques, including praise and imitation of what the child is doing. Other behavioural techniques, such as child management strategies, including how to use direct commands, reinforcement and time-out, are not taught to parents before they attained skills at the preset level of the traditional child-centred play therapy techniques.

Thus, of the commomly used models of BPT available in New Zealand, only one model, Triple P, is free from elements of CPRT. Therefore, in order to consider the effects of BPT in contrast to CPRT, Triple P will be an exemplar of BPT.

Triple P-Positive Parenting Programme was developed at the University of Queensland in Brisbane, Australia by Sanders and colleagues (2001) through some initial efforts in studying the effects of the parents' implementation of two behavioural procedures, namely child management training (CMT) and planned activities training (PAT), on their preschool-

aged children with behavioural problems, including oppositional, disruptive, noncompliant and demanding behaviours, in clinic and home, using single-subject analysis design (e.g., Dadds, Sanders, & James, 1987; Sanders & Dadds, 1982; Sanders & Plant, 1989). Table 5 summarises the specific skills taught in CMT and PAT procedures. Later, Triple P was developed as a multiple-level family intervention, which is rather comprehensive compared to these two behavioural procedures.

Table 5

Specific Skills Taught in CMT and PAT

Intervention phase / procedure	Target	Specific skills taught
Child management training (CMT)	To increase a child's appropriate behaviour	Descriptive praise; Direct instruction; Non-aversive social attention; Behavioural correction procedure (time-out)
Planned activities training (PAT)	To reduce a child's inappropriate behaviour	Incidental teaching, Behavioural self-management strategies; Arranging activities for children on restrictive schedules

Triple P is a five-level behavioural family intervention which builds upon social learning models, including the social information processing models and Patterson's principles of coercive family process, applied behavior analysis, developmental models of children's social competence, developmental psychopathology and the broader ecological context for human development. Triple P is a treatment plus prevention approach implemented through a series of different interventions to address a wide range of childhood issues. The programme focuses on the parents' self-regulation, which is defined as 'a process whereby individuals are taught skills to modify their own' behaviour (Sanders et al., 2001, p. 17). It aims to empower parents with knowledge, skills, confidence and resources, in order to

establish a nurturing environment for their children to exercise social skills as well as emotional and behaviour regulation (pp. 3-25).

The principles of positive parenting in Triple P include (a) ensuring a safe and engaging environment, (b) creating a positive learning environment, (c) using assertive discipline, (d) having realistic expectations, and (e) taking care of oneself as a parent (Sanders, Markie-Dadds, & Turner, 2003). It outlined that positive parent-child relationships could be established by three strategies, (a) brief quality time, (b) talking to children, and (c) showing affection. Consistent with other behavioural therapy, this aspect of parent training is rather brief and subtle as compared to the emphasis on behavioural strategies, including (a) encouraging desirable behaviour, such as using descriptive praise, giving attention and providing engaging activities; (b) teaching new skills and behaviours, such as setting a good example, using incidental teaching, using Ask, Say, Do, using behaviour charts; and (c) managing misbehaviour, such as establishing ground rules, using direct discussion for rule breaking, using planned ignoring for minor problem behaviour, giving clear, calm instructions, backing up instructions with logical consequences, using quiet time for misbehaviour and using time-out for serious misbehaviour (Sanders et al., 2001, pp. 10-11).

However, only the level-four Triple P, namely Standard Triple P (STP) is a therapist-led comprehensive intervention specifically designed for young children with behaviour problems similar to CPRT. Standard Triple P is an intensive parenting programme that is designed for parents of children, from birth to 12 years old, with severe behavioural problems. It consists of seven training sessions of about 60 to 90 minutes each, and includes three home visits of about 40 to 60 minutes each over two to three months. The intervention is delivered in an individual format following the protocol outlined in the practitioner's manual for STP (Sanders et al., 2001). During the training sessions, parents learn to set goals, while learning positive parenting skills and child management skills. The *Every*

Parent's Family Workbook (Markie-Dadds, Sanders, & Turner, 2000) and the video episodes from *Every Parent's Survival* Guide (Sanders, Markie-Dadds, & Turner, 2004) are used to facilitate parents in learning new skills in addition to modelling, role-play, rehearsal, feedback and homework tasks (Sanders et al., 2003).

Sanders and colleagues aimed to determine and demonstrate the effectiveness of Triple P on behavioural problems in pre-schoolers through randomised control trials (RCT); however RCT studies aimed at evaluating the effects of STP on child disruptive behaviour are limited (e.g., Bor, Sanders, & Markie-Dadds, 2002; Sanders, Markie-Dadds, Tully, & Bor, 2000). Bor, Sanders, and Markie-Dadds (2002) aimed at evaluating the effects of STP, on pre-schoolers with co-existing early onset of conduct problems and attention or hyperactive difficulties. A total of 87 families, with a 3-year-old child, were included. The intervention consisted of seven individual sessions in a clinic setting and three at the participants' homes, for a total of 10 sessions, lasting approximately 60 to 90 minutes. Three clinical psychologists and four psychologists completing post-graduate training in psychology were assigned as the trainers who worked with the families. Seventy two percent of the families completed at least nine intervention sessions and the post-assessment and 88% of them were reassessed one year following the completion of the intervention. At post-intervention, the treatment-group children showed a significantly higher reduction in the levels of disruptive behaviour than children in the wait-list condition, as indicated on mothers' reports on the *Eyberg Child Behavior Inventory*, as well as on the *Parent Daily Report*. Moreover, 62% of the children showed clinically significant improvement on ECBI. Parents also reported significantly lower levels of dysfunctional parenting practices on the PS. Owing to the low-rate of negative parental behaviour during observation at baseline, the authors indicated the effects of the reduction in negative parental behaviour are not justified.

Three meta-analysis studies were found to determine the overall effectiveness of Triple P-Positive Parenting Programme (e.g., Graaf, Speetjens, Smit, Wolff, & Tavecchio, 2008; Nowak & Heinrichs, 2008; Thomas & Zimmer-Gembeck, 2007). Thomas and Zimmer-Gembeck (2007) reviewed 11 studies of Triple P, dated between 1980 and 2004, to determine and compare the interventions outcomes. The selected studies involved caregivers of children aged between 3 and 12 years with clinical or borderline ranges of behavioural problems. Of these, 11 studies assessed the efficacy of varying levels of Triple P, including STP in three studies. The findings of an independent group comparison between STP and wait-list indicated that STP yielded a medium effect size on child behaviour through parent-report (d= 0.69) and father-report (d= 0.60), but a small effect size on child behaviour (d = 0.22) was found using clinic observation. In another study, Nowak and Heinrichs (2008) reviewed 55 Triple P randomised trials, mainly of Level 4 and Level 5. Overall, positive effects of Triple P were found on parenting (d = 0.38), child problems (d = 0.35) and parental well-being (d = 0.17) at post-intervention. In particular, the findings suggested that STP, which was delivered in an individual format, produced a small to medium effect size on child problem (d = 0.43) and parenting (d = 0.41) at post-intervention through maternal-reports. Overall, greater intervention effects were found in families with younger children with a mean age of 5.5 years on all measures. While Graaf, Speetjens, Smit, Wolff, and Tavecchio (2008) reviewed the effectiveness of different delivery formats of the Level 4 Triple P, in group and individual formats, on children's behavioural problems of 14 randomised clinical trial meta-analytically, only one study employed an individual format of STP as an intervention. Therefore the findings of this meta-analytical study of Triple P would have limited value in concluding the specific effect of STP, thus they were not discussed in here.

Despite the consistent research on child behavioural problems, a few differences were noted between the characteristics of the earlier studies of Sanders and colleagues and the later

studies of Triple P. Firstly, the research design has been changed from the use of single-subject methods (Dadds, Schwartz, & Sanders, 1987; Sanders & Dadds, 1982; Sanders & Plant, 1989) to randomised-group-controlled methods. Secondly, the target group has been extended from pre-schoolers to children aged up to 12 years. Thirdly, direct observations have been replaced by standard rating scales, such as ECBI and PS, in measuring child and parent outcomes in most of the recent studies. Lastly, in terms of findings, Sanders and colleagues' early studies (Dadds, Sanders, et al., 1987; Sanders & Dadds, 1982; Sanders & Plant, 1989) showed mixed and inconclusive findings of the CMT and the PAT on parent and child's observed behaviours, while the later randomised-controlled studies of Triple P reported consistently positive outcomes on parent and child behaviours through parent-reports on standard rating scales. In addition to a tendency for improvement in child observed behaviours as shown in the above studies, a recent systematic review and meta-analysis of Triple P found an overall medium effect size (*ES*=.501) on child's observed behaviours. However, both Nowak and Heinrich (2008) and Sanders, Kirby, Tellegen, and Day (2014) revealed that Triple P procedures had insignificant effect sizes on child and parent's observed behaviours. These findings did not help to explain the effect of Triple P on observed parental behaviour and thus the effect of parental behaviour upon the positive changes in child's observed behaviours.

Summary and Reflection

Overall, all types of parent intervention reviewed above have been shown to produce positive outcomes in parents and their children. All of these parent interventions, including, but not limited to BPT, STP, FT, CPRT, IY and PCIT, were grounded in different theoretical underpinnings or a combination of different approaches and strategies. Each intervention is unique, in terms of characteristics and principles and strategies, in achieving positive changes in parents and their children. The variation in methodology, research design and assessment

used in assessing the outcome of each parent intervention, prevent a fair and reliable comparison of outcomes between the above parent interventions, even with meta-analytical studies. Therefore, the differences in outcomes of a one parent intervention over another in addressing child behavioural problems, in terms of superiority, remain unanswered.

Meanwhile, the development of parent intervention in addressing child behavioural difficulties has drifted from the focus on parenting behaviour to the parent-child relationship (Cummings & Wittenberg, 2008). These changes are directly reflected in the parent training and parent-child interventions that have been developed in the past two decades, regardless of theoretical approaches. For example, IY, PCIT, FT, and CPRT are underpinned by different theoretical frameworks, which recognise the importance of establishing a positive bond between parent and child. The key differences between IY and PCIT, and CPRT and FT are (a) the elements utilised in each intervention to build the parent-child relationship and (b) the criteria of the defined relationship. Regardless of the differences, to date, empirical findings of the effect of an improved parent-child relationship on child behavioural problems are still limited and thus more studies are needed in order to increase our understanding of this specific treatment variable on parents and children's behaviours.

Problem Statements

Regardless of the availability of well-researched and evidence-based interventions at present that target the issue (Eyberg et al., 2008), it is becoming increasingly evident that there is a high prevalence of behavioural problems in young children across nations (e.g., Australia Institute of Health and Welfare, 2010; Child and Family Statistics, 2010; Elhamid et al., 2009). In fact, it is the most common problem presented by children in mental health services (Garland et al., 2010). Studies indicate that nearly one third of those who received an intervention for child behaviour problems failed to obtain positive change that was clinically significant at the conclusion of the intervention (Abrahamse et al., 2012; Chase &

Eyberg, 2008), while nearly half of them who improved immediately after the intervention relapsed after a given time-frame (Eyberg et al., 2001; Furlong & McGilloway, 2015). The above circumstances indicate that child behavioural problems are complex and may require more than a simple solution. Moreover, owing to the persistency and complexity of child behavioural problems and the limited outcomes of the mainstream parental interventions for a portion of parents of children with persistent and intensive behavioural problems, the investigation of alternative yet effective interventions, such as FT, is becoming a new and important area of research focus in recent decades.

Rationale for the Present Study

As shown in the review, CPRT and STP were found to be the most distinct from one another, in terms of theoretical background and the intervention components, in addressing behavioural problems in young children. For instance, CPRT focuses on building the therapeutic relationship between child and parent as the central component of the entire intervention. In contrast, as a typical behavioural parent training intervention, STP emphasises teaching parents to use behavioural consequences to alter their child's behaviour.

Given the contextual difference in terms of theories and approaches between CPRT and STP, further investigation of both parent interventions, specifically in addressing child behavioural problems, is of importance. For example, a single-subject study of the outcomes of CPRT and STP, which focuses on investigating intra-participant effects, would improve our understanding of how each intervention works for a specific population of parents and children. Using the same research designs, functional relations between the specific products or strategies used in each intervention on specific parent and child outcomes could be explored (Horner et al., 2005).

Chapter 3: Study of Child-Parent Relationship Therapy and Positive Parenting Programme

The aims of the present study (Study 1) were to study (a) the outcome of two different interventions, namely Child-Parent Relationship Therapy and Standard Triple P, and (b) the relationship between changes in negative child behaviour and the strategies taught to the parents in each intervention individually.

Research Objectives

The purpose of the present study was to assess the outcomes of CPRT and STP, when implemented on an individual basis, on parents and their children with behavioural problems. To determine how each programme works within each participant, the intervention outcome on child behaviour was assessed through parent- and teacher-reports, behavioural diaries and observations, while its impact on parental behaviour was assessed through parent-reports and direct observations. In addition, the present study attempted to address several of the aforementioned limitations in the previous studies, particular in the CPRT research. In order to accomplish this task, the present study aimed to assess the outcome of the interventions on a specific child issue, child behavioural problems, to aid in evaluating the impact of each intervention for a particular problem or child population.

Secondly, a single-subject design, which is methodologically sound, was used to provide reliable data. Furthermore, the findings were enriched by including third party reports, behavioural diaries and direct observations to provide additional data on parent-reported intervention outcome. In addition to post-intervention assessment, a 6-month follow-up assessment was carried out to provide information regarding the maintenance effect of each intervention on the parents and their children. In order to best assess the impact of both interventions in the context of this study, a number of dependent variables were studied: (a) child behavioural problem, (b) child self-concept, (c) parenting skill. In

addition, the impact of the process and the specific components taught in each intervention on child behaviour were explored.

Research Questions

1) Does the programme lead to a decrease in parent recorded negative child behaviour?
2) Does the programme lead to an increase in parent's use of the taught strategies in the video-recorded parent child play session?
3) Are there corresponding changes in children's responses in the video-recorded parent child play sessions?
4) Does the programme lead to a reduction in reported behaviour problems, an improvement in reported child self-control and child self-concept?
5) Are there any relationships between changes in negative child behaviour and the strategies taught in each intervention?
6) What are the parents' experiences of the programme?

Research Context

Studies 1 and 2 were carried out within the context of the 2010 Canterbury Earthquakes. Since the earthquakes, most of the families in the Christchurch region were facing a number of challenges and uncertainties in their daily livings for years, such as, dislocations to their homes, schools and communities. As a result, only a small number of families responded to the recruitment in both studies. The approved research outline for a group randomised-controlled outcome study was revised in respond to the insufficient number of the recruited families. The plan of both studies has developed into a further consideration of the applicability of the study and the experimental therapy for the Christchurch community. For example, (a) the initial group randomised-controlled trial of two different interventions was replaced with single-subject designs in Studies 1 and 2; (b) the group delivery method for both interventions (Level-4 Triple P & CPRT) was replaced with an individual delivery

method; and (c) the corresponding research objective and research questions were revised accordingly.

Research Design

Study 1 had a single-subject design which consisted of a baseline phase, an intervention phase, and a follow-up phase, repeated across four families. Parents were randomly assigned to one of two intervention phases comprising either CPRT or STP. Approval was granted from the University of Canterbury's Human Ethics Committee, for conducting this study (Appendix A1, p.321).

The single-subject design was considered to be an acceptable design for several reasons. It is recognised by the American Psychological Association (APA) as a type of research design that competently determines an intervention as an evidence-based practice (2005). Given that the CPRT is not presently considered to be an evidence-based intervention (Ray & Schottelkorb, 2010), this study was designed to assess its outcomes empirically. The single-subject design also allows the researcher to exercise ethical considerations in examining the intervention's effect, without exploring a large number of families in a randomised contolled-outcome trial (Blampied, 2001). Given that both the child's and parent's behaviours change over the course of the intervention, these changes can be best captured using single-subject design (Cooper, Heron, & Heward, 2007). Examining the sequential changes within the intervention phase and across phases means the functional relationship between a child's and a parent's behaviour could be competently demonstrated using single-subjet design.

Participants

The participants were four families whose children met the criteria for behavioural difficulties as indicated by the ECBI (Eyberg & Pincus, 1999) together with the remaining criteria at baseline. All children were male and from European New Zealand families. The

boys were 49, 70, 55 and 70 months of age at baseline. Two of the boys attended a kindergarten (*n*=2) and the other two attended a primary school. Class teachers of all boys were also invited to participate in the study.

Parents in three of the families had tertiary degrees, while the parent in the other family did not. Three families were two-parent families and in the other family the parents were separated. All fathers were in full-time paid employment. All mothers were the primary caregivers of their children and self-identified as having difficulty in dealing with their sons' behavioural problems. All mothers reported that their sons started to show some kind of behavioural problems such as temper-tantrums and aggression at least a year prior to the recruitment. One of the boys had received Speech and Language Therapy when he was 2-year-old and his parents had attended a parenting programme at the same time. Only one of the four families had both parents participate in the intervention.

Recruitment and screening. The participants were recruited from 22 kindergartens located in Christchurch, New Zealand. A poster and the brochure for recruitment (Appendix D, p.338) were distributed to the kindergartens and the researcher visited every kindergarten. During the visits, information regarding the study was provided to teachers and parents. As a result, ten parents who were interested in this study contacted the administration officer at the College of Education. Following their queries, each parent was contacted by the researcher within a week for an initial screening interview. The initial screening interviews (Appendix E, p.341) were administered by the researcher through telephone contacts to identify potential families for the present study. These were followed, when appropriate by an intake interview where more information about the family and the child's presentation and history was gathered. In total, as shown in Figure 1 (p.76), 10 families participated in the screening interviews, while two of them were excluded from the study as they did not meet the

inclusion criteria. Three out of eight families who proceeded with an intake interview dropped out before the intervention due to either time restriction or the issue with child care.

Inclusion criteria. There were five inclusion and exclusion criteria. First, the child was between 36 and 72 months at the time of recruitment. Second, the child was rated by his or her parent as on or above the clinical cut-off 130 (60T) on the *Intensity* scale of the ECBI (Eyberg & Pincus, 1999). Third, the child had no debilitating physical impairment, intellectual disability or developmental delay as reported by his or her parent. Fourth, the child was not currently receiving any therapeutic intervention or medical treatment for the behavioural problems as reported by his or her parent. Fifth, the parents self-reported no debilitating physical impairment, intellectual deficit or history of psychosis.

Informed consent. Each parent gave verbal consent to take part in the initial screening interview. During this interview, the study was described and the child's suitability for the study was determined. Subsequently the parents were given the information sheet and signed a consent form (Appendix B1, p.325) prior to attending the intake meeting. Each child's verbal assent was obtained prior to his or her structured self-concept interview, in each phase, by using the following statement: "We are going to talk together today and look at some pictures. I will write down what you say and use it for my University work. I might talk to your Mum/Dad about it afterwards. Is that OK with you?"

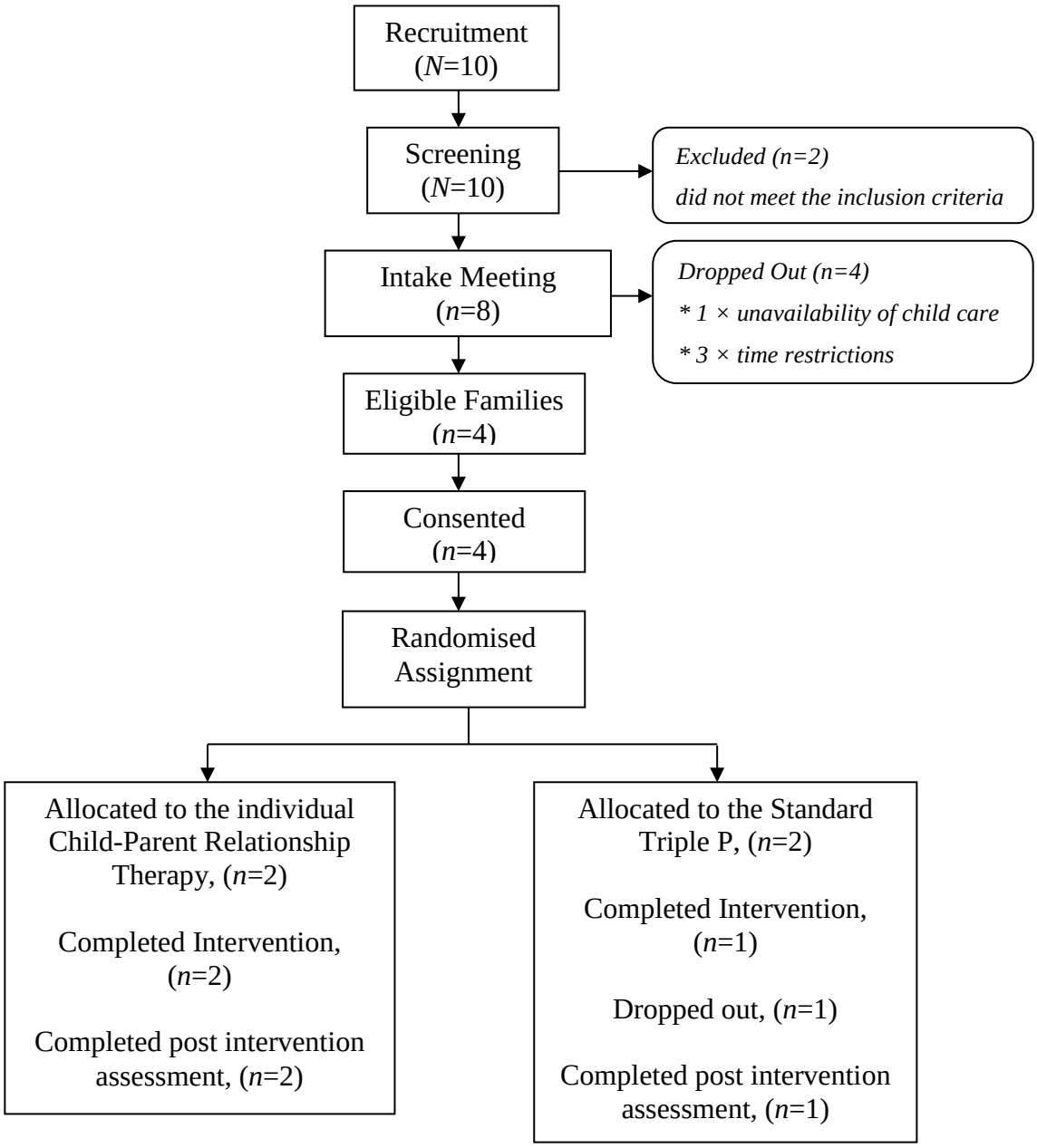


Figure 1. The flow of recruitment and screening

Randomised assignment. The four families, who remained after the screening interview, were randomly assigned to participate in either one of the interventions. A number-draw method was employed where the numbers 1 and 2 represented the STP and the CPRT respectively.

Settings

The intake meetings, assessment sessions and intervention sessions were carried out in the clinic rooms in the School of Health Sciences, University of Canterbury. All clinics were set up with one way mirrors, a "bug in the ear", and video recording devices. For the STP sessions, the clinic was equipped with a DVD-player and a television for participants to watch *Every Parent's Survival Guide* (Sanders et al., 2004), which served as a part of the intervention's material. A waiting room with toys was available for the children when they accompanied their parents for the intervention or assessment. In addition, a clinic room was set up as a playroom for play session demonstrations and the video-recorded parent-child interaction sessions. The clinic playroom was equipped with the categories of toys and materials suggested in the CPRT. These allowed children to engage in (a) pretend play, such as kitchen stove, doll house, and medical kits; (b) aggressive play and acting out, which included a dart gun, rubber knife, boxing set, and rubber alligator; (c) creative play and expression, such as a drawing set, masks, play-dough, a dressing up set, papers and glue; (d) nurturing play, for example dolls, nursing bottles and a baby blanket;(e) constructive play that included building blocks. On the other hand, the home play sessions and home visits were carried out at the participants' homes. A selective toy and materials set was prepared by the parents, according to the above categories, for the home play sessions.

Measures

A set of standardized assessments, *Daily Behavioural Measures*, video observations and coding were used to provide a systematic evaluation of the behaviours of the children and their parents (Haynes & O'Brien, 2000). Multi-informant and time-series measurement methods were utilized to obtain data from parents, teachers and children at different phases. A child's behaviour was assessed using the ECBI (Eyberg & Pincus, 1999) and the *Strengths and Difficulties Questionnaire* (Goodman, 1997) by the parent and the child's class teacher,

respectively. The *Self-Control Rating Scale* (SCRS) (Kendall & Wilcox, 1979) was also used to asses a child's levels of self-control by his or her parent and class teacher. Variables that moderate behavioural problems were assessed using the JPSCS (Joseph, 2004) and the Parenting Scale (PS) (Arnold, O'Leary, Wolff, & Acker, 1993),

In addition, a *Client Satisfaction Questionnaire* was used as a post-intervention and follow-up measure, while the *Family Background Questionnaire* was administered at baseline during the intake meeting. The *Family Background Questionnaire* (Appendix F, p.363) was a brief self-administered questionnaire established for the purpose of the present study. It consists of 13 questions and was used to obtain information regarding the family structure, the child's identity, parents' education and employment status.

Child outcome measure.

Daily behaviour measure. The *Daily Behaviour Measure* in the form of tally sheets was established and used by parents to monitor targeted behaviour of their children during the study. At the conclusion of the consent process, each parent was asked to identify up to three behavioural problems exhibited by their targeted child. Parents were asked to record each occurrence of the target behaviour on a daily basis by marking on the tally sheet (Appendix I, p.388) that was given to them. All parents were given two tally sheets at the conclusion of the consent process to be completed before the intervention and collected by the intervention providers at the first intervention session. During the intervention phase, each parent was given a tally sheet at the conclusion of each intervention session by his or her intervention provider to be completed and handed in by the next session. Data from each parent-report was entered into Microsoft Excel spread sheets and subsequently, the frequency of the targeted behaviours of each child was displayed in a graph for visual analysis. The daily behavioural measure functioned as a daily homework assignment for all parents and is a component of both interventions. It allows the parent to monitor the child's progress to the

intervention goals between sessions. The percentage of the possible days the parents recorded behaviours was calculated to indicate the rate of homework completion.

Eyberg child behavior inventory. *Eyberg Child Behavior Inventory* (Eyberg & Pincus, 1999) was used to indicate the child's behavioural problems. The ECBI (Appendix G) was used by parents to rate their child's behaviour, at baseline, post-intervention, and follow-up. The ECBI had been used as an outcome measure in many studies of behavioural parent training programme for families of preschool-aged children with behavioural problem (Drugli, Fossum, Larsson, & Morch, 2010; Drugli & Larsson, 2006; Drugli, Larsson, Fossum, & Mørch, 2010; Plant & Sanders, 2007; Topham et al., 2011).

The ECBI is designed to assess the overall behavioural problem of a child aged between 2 and 16 years and also the intensity of the behavioural problem. It consists of 36 items, with each of the items describes a child's typical problematic behaviour, for example, whines, interrupts, restless, and refuses to go to bed on time. Each item is rated by parents on two different scales. Parents are asked to identify which item is a current problem for them by *Yes* or *No* on the *Problem* scale. Parents are also asked to specify the regularity of the particular behaviour of their children using a seven-point *Likert* scale on the *Intensity* scale ranging from 1 (*never*) to 7 (*always*).

A total problem score is generated by totalling the number of *Yes* responses on the Problem scale. An *Intensity* score is generated by totalling scores from all ratings to determine the severity of a child's behavioural problem. Raw scores of 130 and above on the *Intensity* scale and 15 and above on the *Problem* scale is used as a clinical cut-off score. Overall, the ECBI has been established as having a high degree of internal consistency for the *Problem* scale (.93) and the *Intensity* scale (.95). A high level of test-retest reliability was also reported on the Intensity scale (.80) and the Problem scale (.85) across a 12-week period (Eyberg & Pincus, 1999).

Strengths and difficulties questionnaire. *Strengths and Difficulties Questionnaire* (Appendix G, p.365) was developed by Robert Goodman (1997). The SDQ is used as a screening tool to identify children with behavioural difficulties as well as being an outcome measure to evaluate changes in the levels of child problem behaviour. The single-sided informant version for teachers of 4- to 10-year-olds students was used at baseline, post-intervention, and follow-up. The SDQ was used in a study of a population trial using a parenting programme with parents of young children by Sanders and colleagues (2008). Changes at the levels of child's problem behaviour of children whose parents participated in the intervention group were reported at post-intervention (Sanders, et al.,2008).

Strengths and Difficulties Questionnaire consists of 25 items. Each of the items describes either a positive or a negative behaviour of a child, for example, often loses temper, kind to younger children, and thinks before acting. The SDQ comprises 5 subscales as follows*: hyperactivity or inattention*, *conduct problems*, *peer relationship problems*, *emotional symptoms*, and *pro-social behaviour*. A parent or a teacher rates a child's behaviour based on the given scale: *certainly true, somewhat true*, and *not true*. A *Total Difficulties* score is calculated by summing the scores of all items from the first four subscales. A *Total Difficulties* score of 16 and above of a child's behaviour on a teacher's report is classified as abnormal. In addition, a *Total Strengths* score is calculated by summing the ratings of all items from the pro-social behaviour subscale. A *Total Strengths* score under 4 is classified as abnormal. Overall, the SDQ has been established with a moderate to high test-retest reliability (.70 to .85) and a moderate internal consistency (.51 to .76) for each subscale (Goodman,1997).

Self-control rating scale. *Self-Control Rating Scale* (Kendall & Wilcox, 1979) is a standardized instrument to measure a child's self-control through a parent's or a teacher's report. The SCRS (Appendix G, p.365) is commonly used as a screening scale to identify

deficits in a child's self-control, as well as being an outcome measure to indicate changes in self-control. The SCRS was used by parents and teachers at baseline, post-intervention, and follow-up. The SCRS was used in a study of parenting intervention with parents of children at risk of severe behavioural problems (Bywater et al., 2009).

The SCRS consists of 33 items. Each of the items describes a child's observed behaviour in a given condition, for example, disrupts games, cooperates, neglects chores, and sits still. A teacher or a parent is asked to score the items (e.g., "Does the child follow the instruction of responsible adults?") using a two-anchored rating system: 1, indicates the highly controllable behaviour (e.g., *followed*), 7, indicates the highly impulsive behaviour (e.g., *neglected*), and 4, indicates the average child's behaviour. A total score is generated by summing the scores of all items, to determine the levels of a child's self-control. A total score of 160 and above of the SCRS was used by Kendall and Braswell (1993) as the cut-off point to refer a child for a cognitive-behavioural intervention. Overall, the SCRS has been established with a high degree of internal consistency (.98.) and a high level of test-retest reliability (.84) (Kendall & Wilcox, 1979).

Joseph picture self-concept scale. *Joseph Picture Self-Concept Scale* (Joseph, 2004) (Appendix G, p.365) is a standardised instrument used to measure a child's self-concept through an interview. It has been constructed for use with children aged between 3- and 7-year-olds. It was administered by the researcher in the present study, at baseline, post-intervention and follow-up. An older version of JPSCS, known as the *Joseph Pre-school and Primary Self-Concept screening test*, was used in some FT studies and significant improvement found between children in the treatment group and non-treatment comparison group (e.g., Costas & Landreth, 1999; Landreth & Lobaugh, 1998; Smith & Landreth, 2003).

The *Joseph Young Child Interview* (Form Y) is divided into two parts. First, a child is asked to draw his or her own face on the blank face outline. Next, the child is interviewed.

The interview consists of the child being shown a pair of pictures that illustrate distinct meaning, for example, a smiling boy and a crying boy. The child is asked to point to the smiling boy and the crying boy. If the child is unable to point to the correct picture, the item is recorded as c*onfused*. If the child is able to point to the correct picture, the child is asked the question, "Now which one is most like you?" If the child picked the picture of the positive attribute, the item is scored 2. If the child picked the negative attribute (e.g., crying) then that item is scored 0.

The JPSCS divides items into three subscales according to a theoretical dimension. The first dimension is *general evaluative contentment*. This subscale contains items such as "One of these boys/girls is very clean, and the other is very dirty. Now which one is most like you?" The second dimension is *significance*. This subscale contains items such as "One of these boys/girls is a bad boy/girl at home, and the other is a good boy/girl at home. Now which one are you?" The third dimension is *competence*. This subscale contains items such as "One of these boys/girls can jump very high, and the other boy/girl can't jump very much at all. Now which one is most like you?" A manual is used to score each item. A *Total Score* is generated by summing the scores for all items. Then, the *Total Score* is classified to determine *positive* self-concept (36-42), *watch- list* (34-35), and *negative* self-concept (0-33) of a child. A child who is classified in the *watch-list* range is considered as borderline between positive and *negative* self-concept (p.16). The *watch-list* range is commonly used as the cut-off point for preschoolers who are at risk for psychological problems. Overall, the JPSCS (Form Y) had been established with a high test-retest reliability (.95) and a high internal consistency for a clinic-referred sample (.77) and a moderate internal consistency for standardization samples (.67) (Joseph, 2004).

Parent outcome measures.

Parenting scale. *Parenting Scale* (Appendix H, p.376; Arnold et al., 1993) is a scale in which parents self-report on their parenting strategies. In the present study, the PS was completed at baseline, post-intervention, and follow-up. It has been used as a screening scale to identify deficits in parenting style as well as being an outcome measure to determine changes in parenting style by completed a parent training programme (Turner & Sanders, 2006).

The PS consists of 30 items. Each of the items describes a given condition in an incomplete statement, for example, "When my child misbehaves..." To answer each item, the parent is asked to circle a number between 1 and 7 on a two-anchored rating system: 1, denotes the positive parenting strategies (e.g., "I do something right away"), while 7, denotes the negative parenting strategies (e.g., "I do something about it later"). A *Total Score* is generated by summing the scores for all items and then divided by 30.

The PS does not provide a clinical cut-off for its total score. However, the higher scores indicate lower levels of effectiveness in parenting, while the lower scores indicate higher levels of effectiveness in parenting. Scores of the three subscales, such as *verbosity*, *over-reactivity*, and *laxness* were generated to classify parenting style. A clinical cut-off is provided for each subscale as follows: 3.1 for *laxness'*, 3.2 for *over-reactivity*, and 4.1 for *verbosity*. The PS has been established with a high level of internal consistency (0.84) and a high level of correlation with behavioural observations of parenting in younger children (Arnold et al., 1993).

Observational measure.

Dyadic parent-child interaction coding system. All video-recorded parent-child interactional sessions were coded using the *Dyadic Parent-Child Interaction Coding System* (DPICS) (Eyberg, Nelson, Duke, & Boggs, 2009). The DPICS (Appendix J, p.391) has been

used in a number of outcome studies of parenting intervention for families of young children at risk of oppositional-defiant disorder or conduct disorder (Borrego & Urquiza, 1999; Bywater et al., 2009; Fossum, Mørch, Handegård, Drugli, & Larsson, 2009; Gardner, Hutchings, Bywater, & Whitaker, 2010). In the present study, the DPICS was used to measure gains in both interventions. However, different strategies were taught in each intervention. For instance, behaviour descriptions and reflective statements were taught in CPRT, while commands and praise were taught in STP. And both intervention taught parents to reduce in asking questions.

To ensure parental gains were equally measured among parents who participated in each intervention, five parental reposnses were chosen, including *command* (C), *information questions* (IQ), *behaviour descriptions* (BD), *reflective statements* (RF) and *praise* (P), to be coded in each interactional segment at each phase across families. In addition, two child responses, *comply* (CO) and *answer* (AN) were coded. Child compliance was coded to measure the corresponding gains of parental commands taught in STP as well as to reflect the general rate of compliance in the children in both interventions. While child answer was a corresponding response of the parent's information questions, it used to explore the child's answering rate. Definitions of all coded parent and child responses are shown in Table 6 (p.85).

Table 6

Parent and child responses coded using the DPICS and their definitions.

Parent responses	
Command (C)	A direct or indirect form of statement that directs the vocal or motor behaviour of the child.
Behavioural Description (BD)	A declarative sentences or phrases in which the subject is the child and the verb describes the child's ongoing or immediately completed (< 5 sec.) observable verbal or nonverbal behaviour.
Reflective Statement (RF)	A declarative phrase or statement that has the same meaning child verbalization.
Information Question (IQ)	A question that request specific information from the child other than a brief response (e.g., yes, no, maybe), even if the child gives a brief response (e.g., "dunno") or no response at all.
Praises (P)	A positive evaluation of the child, an attribute of the child, or a nonspecific and specific activity, behaviour, or product of the child.
Child responses	
Comply (CO)	When the child performs, attempt to perform, or stops attempting to perform the requested behaviour within the 5-second interval following a Direct or Indirect Command.
Answer (AN)	A verbal or nonverbal response to an Information Question that provides or attempts to provide the information requested.

In the present study, each mother was asked to engage in a 25-minute parent-child interaction session which was being video-recorded. The mother and child were invited into the playroom. Next, the mother was asked, using the *bug-in- the-ear* device, to carry out three interactional segments that varied in the levels of parental control employed. The first interactional segment was "child-led play", which is consistent with the parent-child interactional approach taught in CPRT that encourages a sense of child directiveness. Therefore, the strategies taught in CPRT were best measured within this interactional segment, where the mother was directed to let her child play with any toys or activities for 10 minutes. Then, the mother was requested to lead the second interactional segment, namely

"parent-led play", which is a suitable condition to measure the parent directive strategies, taught in STP. In this segment, the mother was asked to instruct her child to play with the toys or activities that she introduced, along with her rules, for 10 minutes. For the third interactional segment, namely "clean-up", the mother was asked to instruct her child, over a 5-minute period, to clean-up all the toys in the playroom, without any help from her. This segment is not sufficient to determine the outcome of CPRT but STP, because in CPRT parents are taught not to ask their children to tidy-up after play sessions.

Inter-rater Reliability

The researcher coded all sessions (N=10), using the DPICS, as described above. To determine reliability of coding, 30% of the video-recorded parent-child interaction sessions were randomly selected and independently coded by a second coder, after a confidentiality contract (Appendix B3, p.343) was signed. Then, the reliability of the DPICS on child and parent responses was determined by the percentage of agreement between coders. The percentage of agreement was measured by the number of agreements divided by the number of agreements plus the number of disagreements. Table 7 (p.87) shows the percentage of agreement of each coded parent and child responses of DPICS. Of the three sessions double-coded, the mean agreement was 94% for parent response and 93.5% for child response.

Table 7

Percentage of Agreement of Each Coded Parent and Child Response of DPICS

	Agreement (%)
Parent Response	94.02
Commands	83.5
Information questions	86.6
Behavioural descriptions	100
Reflective statements	100
Praise	100
Child Response	93.5
Compliance	97
Answer	90

Procedures

Because a single-subject design was used in this study, the baseline data of an individual family served as its own control to determine intervention effects by utilising repeated measurements at different phases, including baseline, post-intervention, and follow-up. At each interval, a set of standardised assessments was used and a video observation was made to study the intervention effects. Additionally, the effects of the interventions over time were assessed by the parent's record of child behaviour on a daily basis for one to two weeks at baseline, ten weeks across the intervention phase, and again for two weeks at six-month follow-up.

Baseline. In addition to the ECBI, a parent from each family was asked to complete a set of assessments consisting of the *Family Demography Questionnaire*, the PS, and the SCRS, during the intake meeting. At the same time, the child was interviewed by the researcher using the JPSCS (Joseph, 2004) in a different clinic room. Following the completion of the above instruments by the parent and the child, a 25-minute parent-child interaction session of the mother-child dyad was carried out and video-recorded in a clinic playroom. A parent from each family was asked to record the child's targeted behaviour,

using the *Daily Behavioural Measure*, for up to two weeks and return it on the first intervention session. The SDQ and the SCRC were mailed to the class teacher of each participating child. The class teachers were asked to return all the completed questionnaires, using the self-addressed postage-paid envelope that was provided to them, prior to the beginning of the intervention.

Intervention phase. The parents received either CPRT or STP. A brief summary of the content of each programme is shown in Table 8.

Table 8

A brief summary of the content of the CPRT and the STP

Content of Intervention Session		
Session	Child-Parent Relationship Therapy	Standard Triple P
1	Introduction Focus on parent-child relationship. Reflective responses. Handling parental mistakes.	Initial Interview Replaced by the initial screening (p.4) interview and preliminary meeting (p.8).
2	Basic principles of non-directive play session. Promote parent's self-awareness and self-acceptance. Introduces toy checklist.	Sharing of assessment findings. Discussion of the baseline data. The causes of child behaviour problems (watch "*Every Parent's Survival Guide*").
3	Play Sessions Do & Don't Play Session Procedures Basic Limit Setting in play session	Positive parenting strategies. Parents choose two positive parenting strategies to practice.
4	Limit Setting : A-C-T A-acknowledge the child's feeling C-communicate the limit T-target acceptable alternatives	Managing misbehavior with planned ignoring, clear and calm instructions following by logical consequences, quiet time or time-out.
5	Home visit- supervises play session. Why Use the Three-Step A-C-T Method Precise messages Implication of different messages	Practice session 1 (Home visit). Parent reviews goals and sets up a practice exercise with the child. Reviews practice and sets goals for further practice.

Content of Intervention Session

Session	Child-Parent Relationship Therapy	Standard Triple P
6	Choice-Giving Methods How to teach the child responsibility & decision-making Provide two positive choices to promote decision-making.	Practice session 2 (Home visit). Parent reviews goals and sets up a practice exercise with the child. Parent identifies strengths and weaknesses and set further goals for change.
7	Home visit- supervises play session. Esteem Building Responses Developing a child's sense of competence Discuss positive character qualities	Practice session 3 (Home visit). Parent reviews goals and sets up a practice exercise with the child. Parent identifies strengths and weaknesses and sets specific goals for change.
8	Home visit- supervises play session. Encouragement vs. Praise Encourage the effort rather than praise the product.	Planned activities training for 'high-risk-situations'. Parent designs, uses and monitors her/his own planned activities routines.
9	Giving choices as consequences for non-compliance behaviours. Generalizing limit setting outside the play session.	Practice three planned activities. Develop a planned activities routine. Using planned activities with the child in three different 'high-risk-situations'.
10	Structured doll play. Parent's self- reflection and evaluation on family's progress. Planned strategies to maintain positive changes and challenging situations.	Family survival tips and ways to maintain the changes parent has made. Parent reviews family's progress. Planned more parenting routines for high-risk situations.

Child-parent relationship therapy. Parents who participated in the CPRT received ten weekly 60-minute individual sessions with the researcher, rather than a 120-minute session suggested for a group. In addition, five 30-minute filial home play sessions were included as homework. The manual has ten sessions to be conducted at varied settings, such as a clinic, a school or a community centre. This includes three sessions in which the parents bring in a video-tape of their home-play sessions for discussion.

In the current study, however, seven sessions were conducted at the clinic while three sessions were carried out at the parent's home, replacing the need for parents to video their own special home play sessions. After the third sessions, parents were asked to practice skills from CCPT in their first weekly 30-minute special home play session with their child. In addition, parents were asked to complete weekly homework tasks to strengthen their ability to adapt the new attitude and skills learned in each session.

The CPRT is aimed to train the parents to establish a therapeutic relationship with their child in addressing child behavioural problems. The parents were taught the basic skills of the CCPT approach that emphasises nondirective forms of interaction with their children. For example, following the child's lead and verbally tracking their child's actions, emotions and attempts. The parents were also taught to refrain from naming objects such as toys, thus allowing or encouraging their children to use the object in pretend play or symbolic play. Moreover, the parents were introduced to more advanced concepts of play therapy skills such as returning responsibility, when their children asks for their opinion by saying "Here you can choose.", and esteem building by acknowledging their children's efforts by saying "You are colouring the picture carefully." Most importantly, it aims to teach the parents to generalise those skills and attitudes outside the play sessions (Bratton et al., 2006).

The CPRT provider in the present study was the researcher, a female PhD student at the School of Health Sciences. She was a registered counsellor and certified counselling supervisor with ten years of clinical experience with families whose children presented with behavioural and emotional issues in Malaysia. In addition, she had received prior training in play therapy, FT and STP.

Standard Triple P. Parents who participated in STP received 10 weekly 60-minute individual sessions with a registered psychologist, who was accredited to provide the programme. The intervention consisted of seven clinic visits and three home visits over a

period of 10 weeks. The three home visits were carried out at the fifth, sixth, and eighth sessions to supervise the parents for the practise tasks they selected. The intervention was delivered by the psychologist according to the protocol outlined in the practitioner's manual for STP (Sanders et al., 2001).

During the seven 60-minute clinic visits, the parents learned to set goals and were taught positive parenting skills, such as descriptive praise, planned ignoring, and to give clear, calm instructions. The programme provider used the *Every Parent's Family Workbook* (Markie-Dadds et al., 2000) and the video episodes from *Every Parent's Survival Guide* (Sanders et al., 2004) to facilitate the parents in learning new skills. The psychologist helped parents acquire new skills and knowledge through discussions, practice and feedback. Subsequently, the parents practised new skills through role-play with the psychologist and received feedback from her before they applied the skills with their children. Between sessions, parents were asked to complete homework tasks to strengthen their learning.

The STP provider in the present study was a registered psychologist who was also an accredited STP provider and Triple P training provider. In addition, she was a clinical educator in the Child and Family Psychology Programme at the School of Health Sciences, at the time of the study. She had more than 20 years of clinical experience with families whose children presented with behavioural and emotional issues in New Zealand.

Post-intervention. Following the conclusion of the intervention phase, a set of post-intervention assessments was given to the families who had completed their intervention. The mothers were asked to complete a set of post-intervention assessments, which consisted of the ECBI, the SCRS, the PS and the *Client Satisfaction Questionnaire*. In addition, a post-intervention session was attended by each family a week following the conclusion of their interventions. During that session, each child was interviewed again using the JPSCS. Following that, a 25-minute parent-child interaction session with the mother-child dyad was

carried out and video-recorded in the clinic playroom. An assessment package, which consisted of the SDQ and the SCRC, was mailed to the class teacher of each participating child. The class teachers were asked to return all the completed questionnaires, using the self-addressed postage-paid envelope which was provided to them.

Six-month follow-up. Each family was followed up individually for a period of six months after the conclusion of their intervention. Postcards were sent to all families followed by telephone contacts. Then, home visits were carried out for all families. During the home visits, parents were asked to provide information as follows: the child's school, room and class teacher. In addition, an appointment for a follow-up session was given to each family.

The follow-up sessions were attended by all families who completed their intervention. During the follow-up meeting, the mother was asked to complete to the ECBI, the SCRS and the PS, while her child was interviewed by the researcher using the JPSCS. Following that, a 25-minute parent-child interaction session of the mother-child dyad was carried out and video-recorded in the playroom. In addition, parents were asked to record their child's targeted behaviours, which had been identified prior to the beginning of the intervention using the *Daily Behaviour Measure,* for the following two weeks.

Teachers were contacted at follow-up through school visits. During the school visits, the assessment packages, which consisted of the SDQ, the SCRC, a copy of the ethics approval letter, a copy of the parent's consent form, and a copy of the information sheet for the present study were given to the class teachers. The class teachers were asked to complete both questionnaires. The completed questionnaires were collected by the researcher on school visits.

Methods of Data Treatment and Analysis

Data from the *Daily Behaviour Measure* and the DPICS was transferred into the Microsoft Excel spread sheets. Line graphs for the targeted behaviours of each child and the

parent were generated and examined by visual analysis to study changes in level and trend (Cooper, Heron, & Heward, 1987) at baseline, over the course of the intervention, and at six-month follow-up. The ECBI *Intensity* and *Problem* scores, the total scores of the JPSC, the SCRS, the SDQ for each child and the scores of the subscales on the PS for each parent at each phase were analysed in relationship to the clinical cut-off score for that instrument. The scores on measures at post-intervention and the six-month follow-up were compared with baseline scores to study changes in the child's behaviour and other intervention outcomes.

Results

The results from each family were described in three sections. First, parent and child outcomes for each family were presented individually. Next, the findings of within-intervention analysis which captures changes in child and parent behaviours after the specific content taught to the parents were discussed. Finally, the social validity using parents' comments and reactions toward each intervention were presented.

Family 1. Parent 1 (mother) was randomly assigned to the 10-session CPRT. She attended 10 sessions, including three home visits. The mother and son participated in the baseline, post-intervention, and follow-up video observations.

Daily behaviour measures. Parent 1 nominated three behavioural problems of her son (Child 1) for the *Daily Behaviour Measures* as follows: (a) interruptions (behaviour which interrupted her interactions with others), (b) non-compliance (not following her instructions), and, (c) switching-off (withdrawing from interacting with her). The parent reported on 91 out of 99 possible days which was equal to a 92% of completion rate.

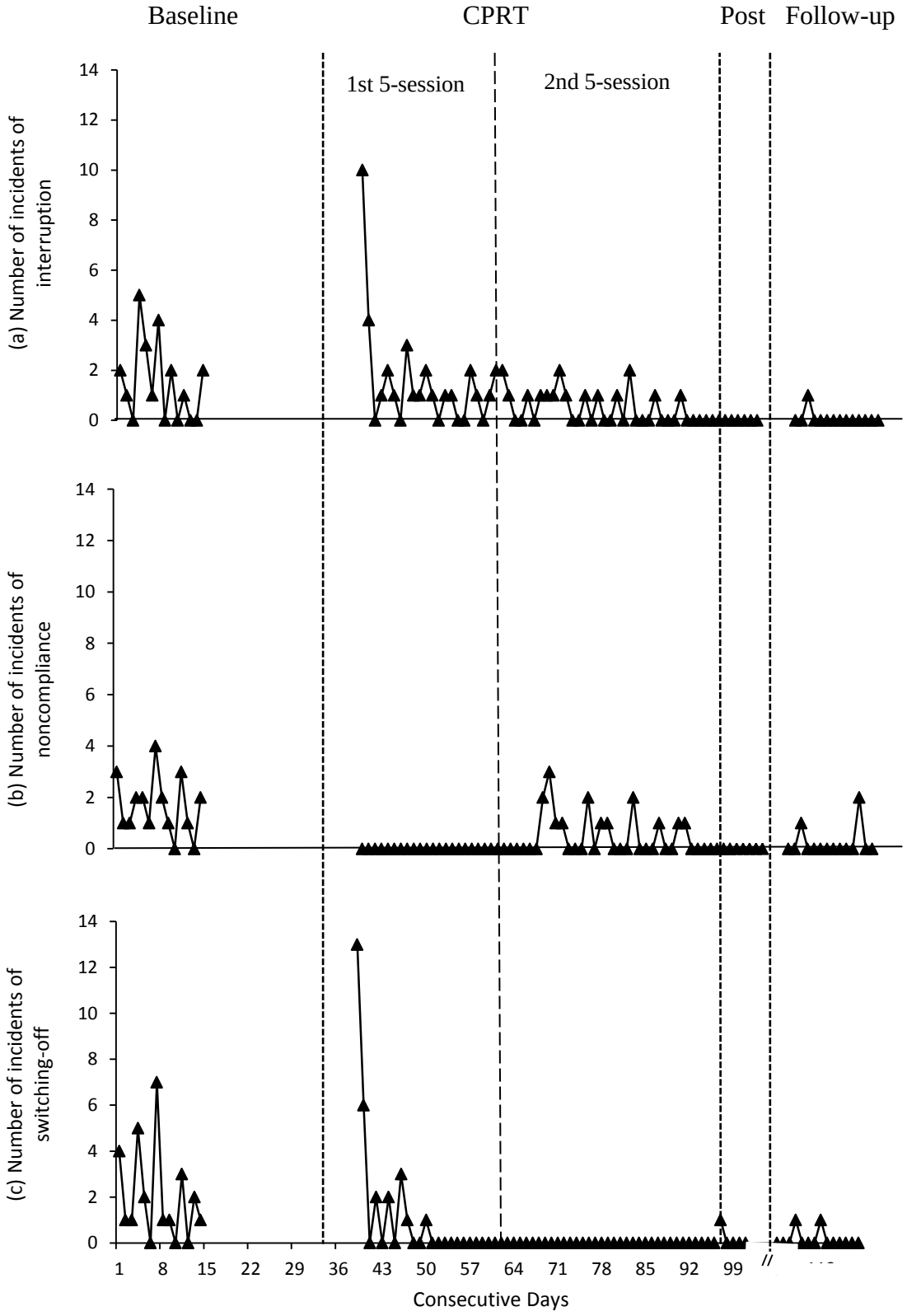
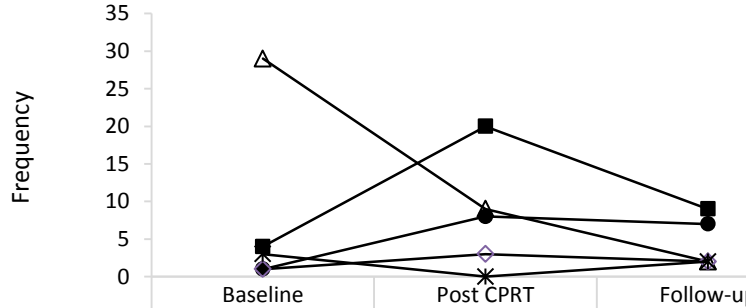


Figure 2. Number of incidents of (a) interruptions, (b) non-compliance, and (c) switching-off recorded by Parent 1 across the experimental conditions

Figure 2 shows the number of incidents of interruptions, non-compliance, and switching-off recorded by Parent 1 across the experimental conditions. At baseline, all behavioural problems of Child 1 were in low to moderate levels. When intervention occurred, all behavioural problems were almost unseen by the 8th session of the CPRT and this gain was remained at follow-up, six months after the conclusion of intervention.

Child-led play observations. Figure 3 and Figure 4 display the results of Parent 1 and Child 1, respectively, on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up.

Baseline. At baseline, Parent 1 predominantly asked *information questions*; she made few *reflective statements* and few *commands* (direct command, *n*=2; indirect command, *n*=1). She also made one *behavioural description*, and *praise* once (unlabelled praise). Given the high levels of *information questions* asked by Parent 1, Child 1 answered nearly half of the *information questions*; however he did not comply with all *commands* given by Parent 1.



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	1	8	7
Reflective Statements	4	20	9
Information Questions	29	9	2
Labelled/Unlabeled Praise	1	3	2
Direct/Indirect Commands	3	0	2

Figure 3. Results of Parent 1 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Post-intervention. At post-intervention, Parent 1 gave more *reflective statements* (i.e., improvement), made more *behavioural descriptions* (i.e., improvement) and gave more *praise* (unlabelled praise, *n*=3) at post-intervention than she had in baseline. While Parent 1 asked fewer *information questions* (i.e., improvement), answering rate of Child 1 increased to nearly 70% (i.e., improvement).

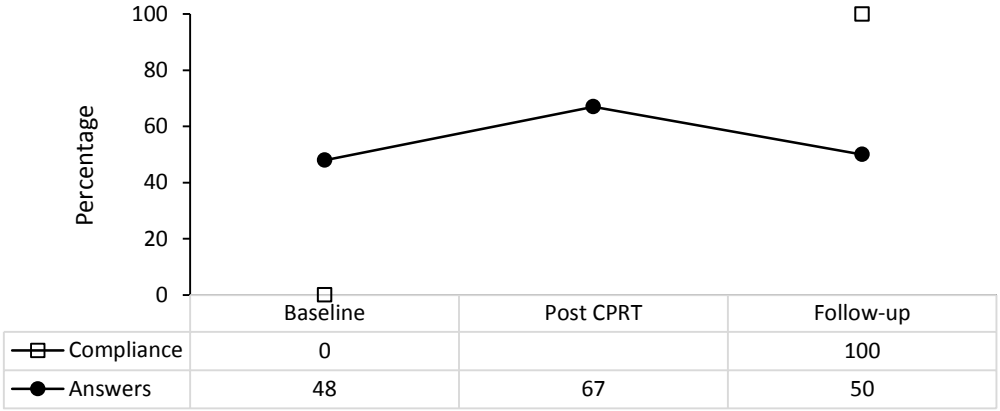
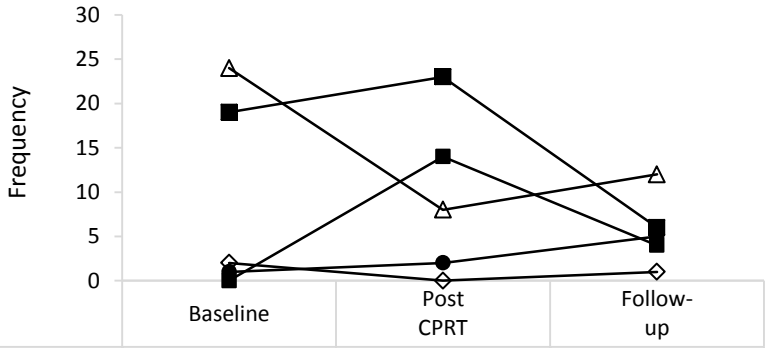


Figure 4. Results of Child 1 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Follow-up. At follow-up, Parent 1 gave more *reflective statements* (i.e., improvement), made more *behavioural descriptions* (i.e., improvement) and gave more *praise* (labelled praise, *n*=2; unlabelled praise, *n*=1) (i.e., deteriorated), made fewer *commands* (direct command, *n*=2) (i.e., improvement) than baseline. In addition, there was a marked decrease in the levels of *reflective statements* compared to post-intervention. While Parent 1 reduced further in *information questions*, Child 1's answering rate returned to the baseline's levels (i.e., no improvement); Child 1 showed a 100% of compliance rate (i.e., improvement).

Parent-led play observation. Figure 5 and Figure 6 shows the results of Parent 1 and Child 1, respectively, on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up.

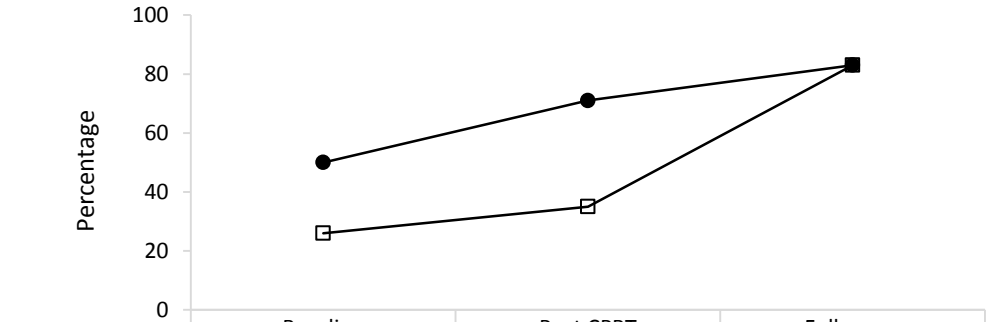
Baseline. At baseline, Parent 1 directed her son to play with the building tools and dressing up with her. During that segment, Parent 1 predominantly asked *information questions* and gave *commands* (indirect commands, *n*=19); she made a *behavioural descriptions*, gave few *praise* (unlabelled praise, *n*=2) but did not gave any *reflective statements*. Child 1 showed low levels of answering and compliance rates (i.e., deteriorated).



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	1	2	5
Reflective Statements	0	14	4
Information Questions	24	8	12
labelled/Unlabelled Praise	2	0	1
Direct/Indirect Commands	19	23	6

Figure 5. Results of Parent 1 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up

Post-intervention. At post-intervention, Parent 1 instructed Child 1 to play with some medical kits and musical instruments. During the segment, she made more *reflective statements* (i.e., improvement), asked fewer *information questions* (i.e., improvement); made more *commands* (indirect commands, *n*=23) than she had in baseline, while *praise* was not evident (i.e., improvement). There was a slight increase in child answering and compliance rates compared baseline (i.e., improvement).



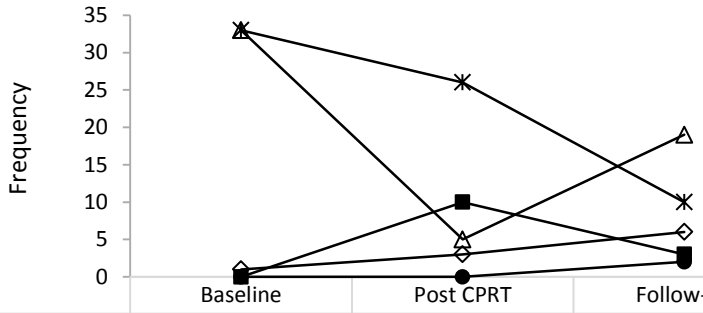
	Baseline	Post CPRT	Follow-up
Compliance	26	35	83
Answers	50	71	83

Figure 6. Results of Child 1 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up

Follow-up. Parent 1 directed her son to play with hats and the toy kitchen during the parent-led play segment at follow-up. During the segement, Parent 1 made more *behavioural descriptions* (i.e., improvement), gave more *reflective statements* (i.e., improvement), while she asked fewer *information questions* (i.e., improvement), gave fewer *commands* (direct commands, *n*=5, indirect commands, *n*=1) (i.e., improvement) and gave fewer *praise* (unlabelled praise, *n*=1) than she had in baseline. Child 1 showed higher levels of answering and compliance rates compared to baseline (i.e., improvement).

Clean-up observation. Figure 7 and Figure 8 display the results of Parent 1 and Child 1, respectively, on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up.

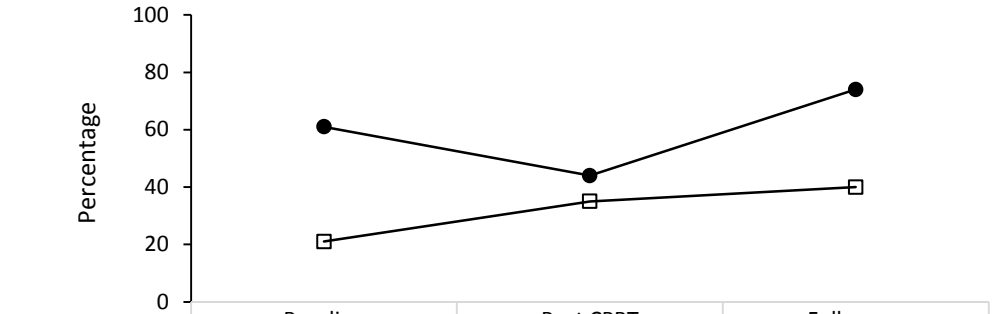
Baseline. At baseline, Parent 1 predominantly used *information questions* as well as *indirect commands* (*n*=33), while other responses were almost not evident, except *unlabelled praise* (*n*=1). Child 1, however, showed low levels of answering and compliance rates compared to baseline.



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	0	0	2
Reflective Statements	0	10	3
Information Questions	33	5	19
labelled/Unlabeled Praise	1	3	6
Direct/Indirect Commands	33	26	10

Figure 7. Results of Parent 1 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up

Post-intervention. Parent 1 gave more *reflective statements* (i.e., improvement) and gave more *praise* (labelled praise, *n*=1; unlabelled praise, *n*=2) (i.e., deteriorated); gave fewer *commands* (direct commands, *n*=1; indirect commands, *n*=9) (i.e., improvement) and asked fewer *information questions* (i.e., improvement) than she had in baseline, while *behavioural descriptions* were not evident (i.e., no improvement). There was an increase in child compliance (i.e., improvement) but a decrease in child answering rate (i.e., deteriorated) compared to baseline.



	Baseline	Post CPRT	Follow-up
Compliance	21	35	40
Answers	61	44	74

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Figure 8. Results of Child 1 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up

Follow-up. At follow up, Parent 1 made more *behavioural descriptions* (i.e., improvement), gave more *reflective statements* (i.e., improvement), gave more *praise* (labelled praise, *n*=6); asked fewer *information questions* (i.e., improvement) and gave fewer *commands* (i.e., improvement), while Child 1 increased his compliance and answering rates (i.e., improvement).

Table 9

Scores of Family 1 on the Standardised Measures across Experimental Conditions

Measures	Baseline	Post-	Follow-up
ECBI-Parent Intensity score	**160** (**68**)	121 (57)	**131** (**60**)
ECBI-Parent Problem score	**21**(**68**)	4 (46)	10 (54)
PS Total Score	3.4	2.0	2.1
JPSCS Total Score	20 (<1)	42 (90)	42 (90)
SCRS-Parent Total Self-Control Score	156	123	124
SCRS-Teacher Total Self-Control Score	90	112	117
SDQ-teacher Total Difficulties Score	4*, 5*	5	3
SDQ-teacher Total Strengths Score	**4***, 5*	**4****	5

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denote clinically significance level. JPSCS data in parentheses are percentile scores. Scores in clinically significant levels as well as borderline were shown in bold. Lower scores in ECBI, SDQ-Difficulties score, SCRS and PS indicate improvement in child behavioural problems and parenting style, respectively. Higher scores in JPSCS and SDQ-Strengths score indicate improvement in child self-concept and self-contol, respectively. * =teacher's scoring was indeterminate, where two possible scores resulted, and both were shown. **=the item "kind to younger children" was not marked by the teacher, who noted "unobserved".

Child and parent functioning. Table 9 displays scores of Family 1 on the standardised measures across experimental conditions. At baseline, the Parent1's reports of the child's problematic behaviour on the ECBI *Intensity* (68T) and *Problem* (68T) scales were at the clinical levels. Child 1's score on the JPSCS was in the classification of *very high-risk negative* self-concept. The teacher-reported child difficult behaviour was in the *normal* range, while the teacher-reported child *strengths* was in the borderline range on SDQ. Both parent and teacher's scores of the child's self-control were in the normal range on SCRS.

After the intervention occurred, Parent 1's reports of the child's problematic behaviour on the ECBI, per *Intensity* (57T) and *Problem* (46T) scales were in the non-clinical levels. The child's score on the JPSCS was in the high positive self-concept range. The parent and teacher's reports of the child self-control per SCRS were in the normative range. However, the decreased score on the parent's report on SCRS indicated a higher level of the child's self-control. In contrary, the increased score of the teacher on SCRS suggested a lower level of the child's self-control at post-intervention. The teacher's report of the child's difficult

behaviour and strengths on the SDQ did not show changes in clinical levels in post-intervention compared to baseline, scores were in the normal and borderline range, respectively. Moreover, the lower PS score at post-intervention indicated an improvement in parenting. At follow-up, positive changes in child and parent functioning were shown on all measures. For instance, Child 1's *Problem* (46T) scores reduced to non-clinical levels. While the *Intensity* score of Child 1 reduced, as rated by Parent 1 on the ECBI, it remained in the clinical levels (60T) six months following the intervention. Moreover, Parent 1 rated herself as improved in parenting on the PS, while Child 1's score on the JPSCS was in the classification of *high positive* self-concept. While the teacher's score of the child's difficult behaviour remained unchanged in the normative range, the teacher's score on the child's strength moved from the borderline to the normative range on SDQ.

Family 2. Parent 2 (mother) was randomly assigned to the 10-session CPRT. The mother attended 10 sessions while the father attended six sessions, including three home visits. The mother and son participated in the baseline, post-intervention, and follow-up video observations. In addition, the intervention provider engaged with the child in a home-play session during the first home visit as requested by the parents.

Daily behaviour measures. The mother nominated three behavioural problems for the *Daily Behaviour Measures* as follows: (a) non-compliance (meaning not following her instructions), (b) temper-tantrums (meaning shouting, screaming and answering back), and (c) hitting (meaning hits his parents or bullies his siblings physically). Figure 9 shows the number of incidents of non-compliance, temper-tantrums, and hitting recorded by Parent 2 across the experimental conditions. At baseline, all behavioural problems of Child 2 were in moderate to high levels. When intervention occurred, all behavioural problems of Child 2 reduced to lower levels compared to baseline and these gains were remained at 6-month follow-up.

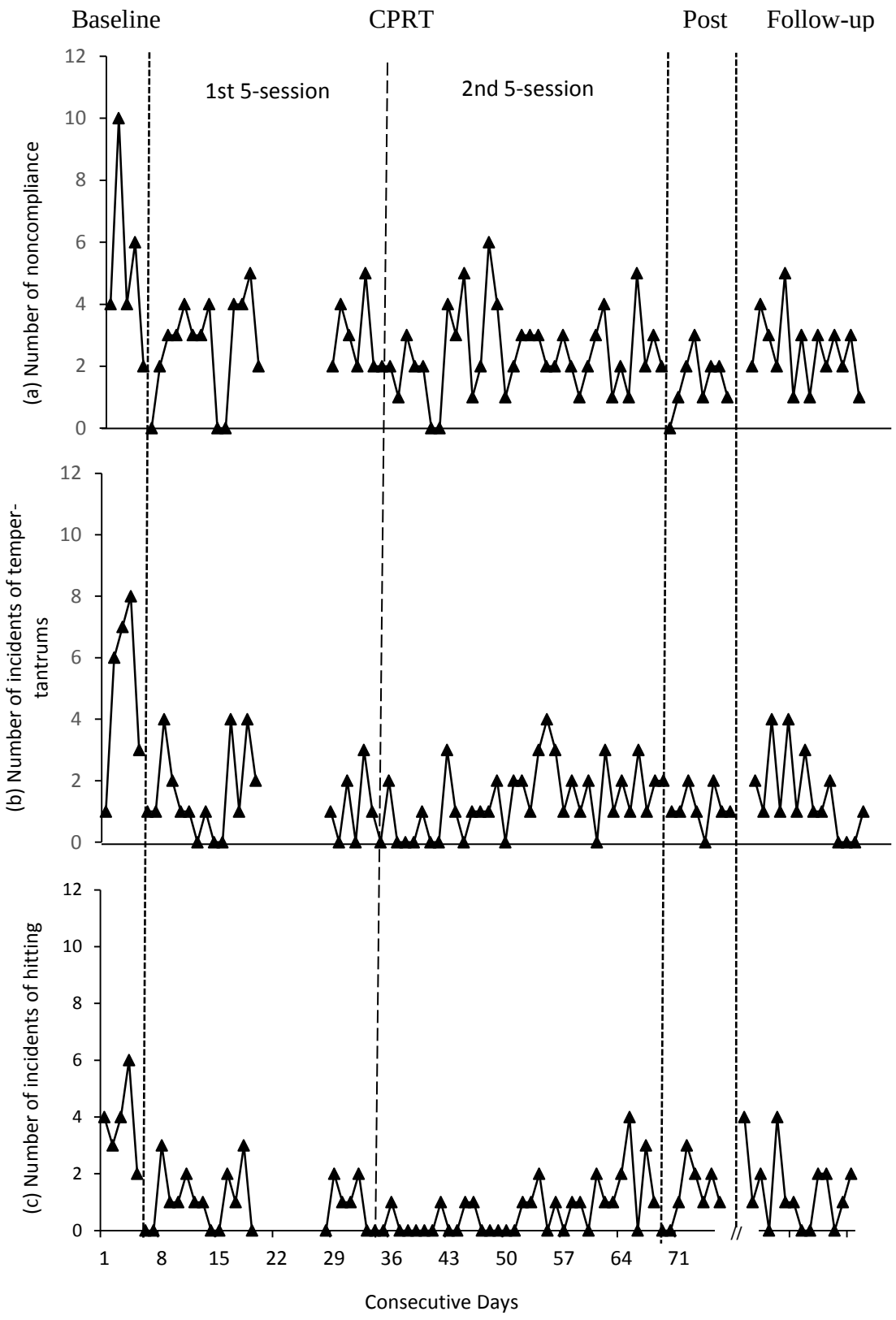
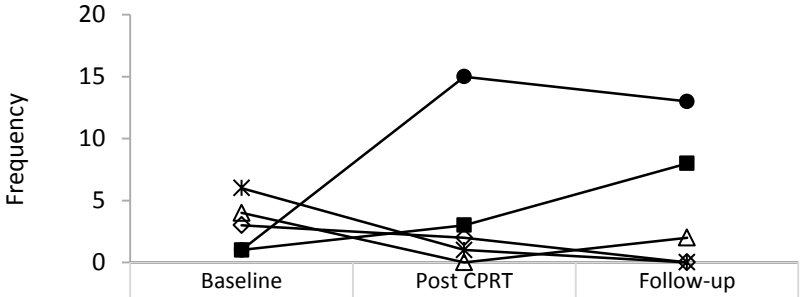


Figure 9. Number of incidents of (a) non-compliance, (b) temper-tantrums, and (c) hitting recorded by Parent 2 across the experimental conditions

Child-led play observations. Figure 10 and Figure 11 display the results of Parent 2 and Child 2, respectively, on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up.

Baseline. At baseline, Child 2 chose to draw but he abandoned that when he was ignored by his mother, he, then, joined his mother for building blocks and engaged in a social conversation with her. Parent 2 predominantly gave *indirect commands* (*n*=6) and asked *information questions*; she also gave few *praise* (unlabelled praise, *n*=2; labelled praise, *n*=1) and gave a *reflective statement* and *behavioural description*. Child 2 showed moderate levels of compliance (67%) and high levels of answering rate (100%).



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	1	15	13
Reflective Statements	1	3	8
Information Questions	4	0	2
labelled/Unlabeled Praise	3	2	0
Direct/Indirect Commands	6	1	0

Figure 10. Results of Parent 2 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Post-intervention. At post-intervention, Child 2 chose to draw for the entire segment and Parent 2 paid full attention on Child 2. During that segment, Parent 2 gave more *behavioural descriptions* (i.e., improvement), made *more reflective statements* (i.e., improvement), she gave fewer *indirect commands* (i.e., improvement) and gave fewer *praise* (labelled praise, *n*=1; unlabelled praise, *n*=1) (i.e., improvement) than she had in baseline and

she did not ask any *information questions* (i.e., improvement). Child 2 showed higher levels of compliance (100%) than he had in baseline (i.e., improvement).

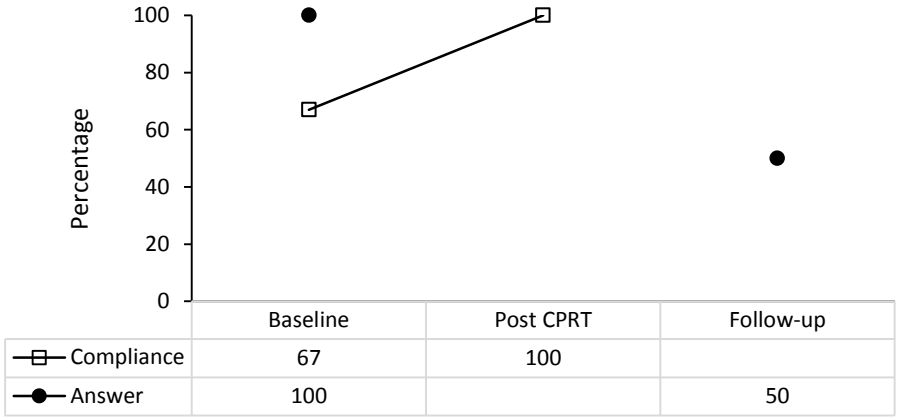
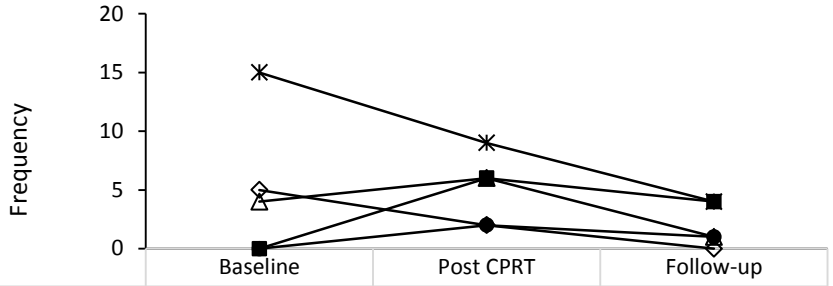


Figure11. Results of Child 2 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Follow-up. At follow-up, Child 2 invited his mother to draw with him. During that segment, Parent 2 gave more *behavioural descriptions* (i.e., improvement), made more *reflective statements* (i.e., improvement), asked fewer *information questions* (i.e., improvement) than she had in baseline, while she did not give any *commands* or *praise* (i.e., improvement). Child 2 showed lower answering rate (50%) compared to baseline (i.e., deteriorated).

Parent-led play observations. Figure 12 and Figure 13 display the results of Parent 2 and Child 2, respectively, on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up.

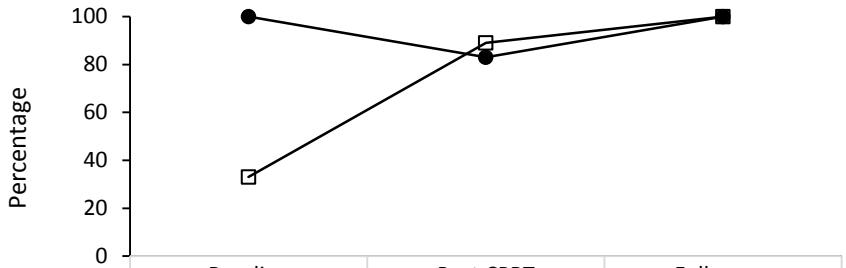
Baseline. During the parent-led play segments, Parent 2 instructed her son to play hand puppets with her. Parent 2 predominantly gave *commands* (indirect commands, *n*=15) while she gave few *praise* (unlabelled praise, *n*=5) and asked few *information questions*.



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	0	2	1
Reflective Statements	0	6	4
Information Questions	4	6	1
Labelled/Unlabeled Praise	5	2	0
Direct/Indirect Commands	15	9	4

Figure 12. Results of (a) Parent 2 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up

Post-intervention. At post-intervention, Parent 2 directed her son to play the "rhyme words" game with her. Parent 2 gave more *reflective statements* (i.e., improvement) and *behavioural descriptions* (i.e., improvement); gave fewer *praise* (labelled praise, *n*=2; unlabelled praise, *n*=0) (i.e., improvement), gave fewer *commands* (indirect commands, *n*=9) (i.e., improvement), however, she asked more *information questions* (i.e., deteriorated) than she had in baseline. Child 2 showed higher levels of compliance (i.e., improvement) but lower levels of answering rate (i.e., deteriorated) compared to baseline.



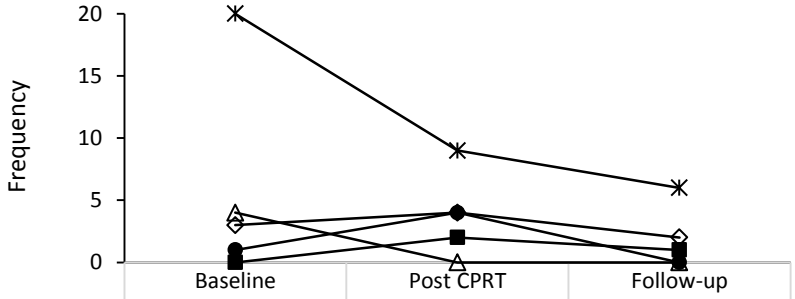
	Baseline	Post CPRT	Follow-up
Compliance	33	89	100
Answer	100	83	100

Figure 13. Results of Child 2 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention, and follow-up

Follow-up. Parent 2 instructed her son to play building blocks with her at follow-up. During the segment, Parent 2 gave more *reflective statements* and *behavioural descriptions*; gave fewer *commands* (indirect commands, *n*=2; direct commands, *n*=2) (i.e., improvement) and asked fewer *information questions* (i.e., improvement) than she had in baseline, while she did not gave any *praise* (i.e., improvement). Child 2 showed higher of compliance and answering rates (i.e., improvement) compared to baseline.

Clean-up Observation. Figure 14 and Figure 15 show the results of Parent 2 and Child 2, respectively, on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up.

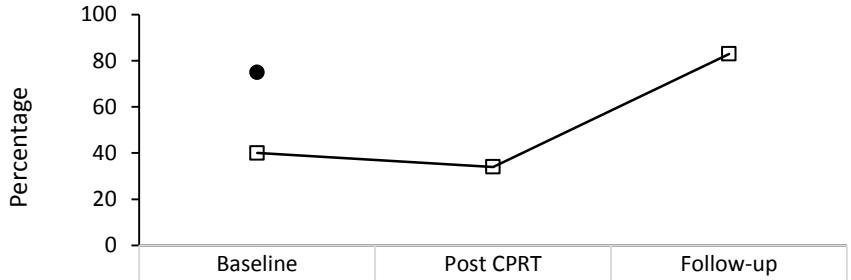
Baseline. At baseline, Parent 2 predominantly gave *commands* (indirect commands, *n*=20), she also asked few *information questions*, gave few *praise* (unlabelled praise, *n*=3) and made a *behavioural description*. Child 2 showed high levels of answering rate and low levels of compliance.



	Baseline	Post CPRT	Follow-up
Behavioural Descriptions	1	4	0
Reflective Statements	0	2	1
Information Questions	4	0	0
Labelled/Unlabeled Praise	3	4	2
Direct/Indirect Commands	20	9	6

Figure 14. Results of (a) Parent 2 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up

Post-intervention. Parent 2 gave more *reflective statements* (i.e., improvement), made more *behavioural desciptions* (i.e., improvement), gave fewer *commands* (indirect commands, *n*=9) (i.e., improvement); gave more *praise* (unlabelled praise, *n*=4) (i.e., deteriorated) than she had in baseline, while she did not ask any *information questions* (i.e., improvement). No changes in child compliance were evident (i.e., no improvement).



	Baseline	Post CPRT	Follow-up
Compliance	40	34	83
Answer	75		

Figure 15. Results of Child 2 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention, and follow-up

Follow-up. At follow-up, Parent 2 gave more *reflective statements* (i.e., improvement); gave fewer *direct* (*n*=2) and *indirect commands* (*n*=4) (i.e., improvement); gave fewer *praise* (unlabelled praise, *n*=2) (i.e., improvement), than she had in baseline, while *information questions* (i.e., improvement) and *behavioural descriptions* (i.e., deteriorated) were not evident. Child 2 showed higher compliance (i.e., improvement) compared to baseline.

Table 10

Scores of Family 2 on the Standardised Measures across Experimental Conditions

Measures	Baseline	Post-	Follow-up
ECBI-Parent Intensity score	**168** (**70**)	**154** (**66**)	**136** (**61**)
ECBI-Parent Problem score	**26** (**75**)	11 (55)	11 (55)
PS Total Score	2.6	2.9	1.3
JPSCS Total Score	40 (73)	42 (90)	42 (90)
SCRS-Parent Total Self-Control Score	120	118	106
SCRS-Teacher Total Self-Control Score	103	63	60
SDQ-teacher Total Difficulties Score	9	4	4
SDQ-teacher Total Strengths Score	8	9	10

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denotes clinical significance level. JPSCS data in parentheses are percentile scores. Scores in clinically significant levels as well as borderline were shown in bold. Lower scores in ECBI, SDQ-Difficulties score, SCRS and PS indicate improvement in child behavioural problems and parenting style, respectively. Higher scores in JPSCS and SDQ-Strengths score indicate improvement in child self-concept and self-contol, respectively.

Child behaviour and parent functioning. Table 10 displays scores of Family 2 on the standardised measures across experimental conditions. At baseline, the Parent 2's reports of the child's problematic behaviour on the ECBI *Intensity* and *Problem* scales were in clinically significant levels. Child 2 score on the JPSCS was in the classification of *moderate positive* self-concept. The teacher-reported child difficulties and strengths were in the normative range on SDQ. Both parent and teacher's scores of the child's self-control were in the normative range on SCRS.

At post-intervention and follow-up, Parent 2's score on the *Intensity* scale reduced but the score remained in clinically significant levels, while the parent's score on the *Problem*

scale changed to non-clinical levels. The JPSCS scores increased and were in the classification of *high positive* self-concept. The parent's and teacher's scores on SCRS and the teacher's scores on SDQ did not show changes in clinical levels compared to baseline, however the scores indicated improvement in child self-control, child difficulties and strengths, respectively.

Family 3. There were 10 sessions of STP, and Parent 3 (mother) attended nine sessions including three home visits. The mother and son participated in the baseline, post-intervention, and follow-up video observations.

***Daily behaviour measures*.** Parent 3 (the mother) nominated three behavioural problems of her son (Child 3) for the *Daily Behaviour Measures* as follows: (a) defiance (meaning resistance to mother's instructions), (b) hitting (meaning bullies sibling physically), and (c) grizzling (meaning grizzling for a snack after a proper meal). The parent reported on 39 out of 91 possible days which is equal to a 43% completion rate. Figure 16 shows the number of incidents of hitting, defiance, and grizzling recorded by Parent 3 across the experimental conditions. At baseline, all behavioural problems fluctuated between low and moderate levels, with an average of three incidents per day across all behaviours. During the early intervention of STP, a slight reduce was evident across all behavioural problems of Child 3, with an overage of 2 incidents per day.

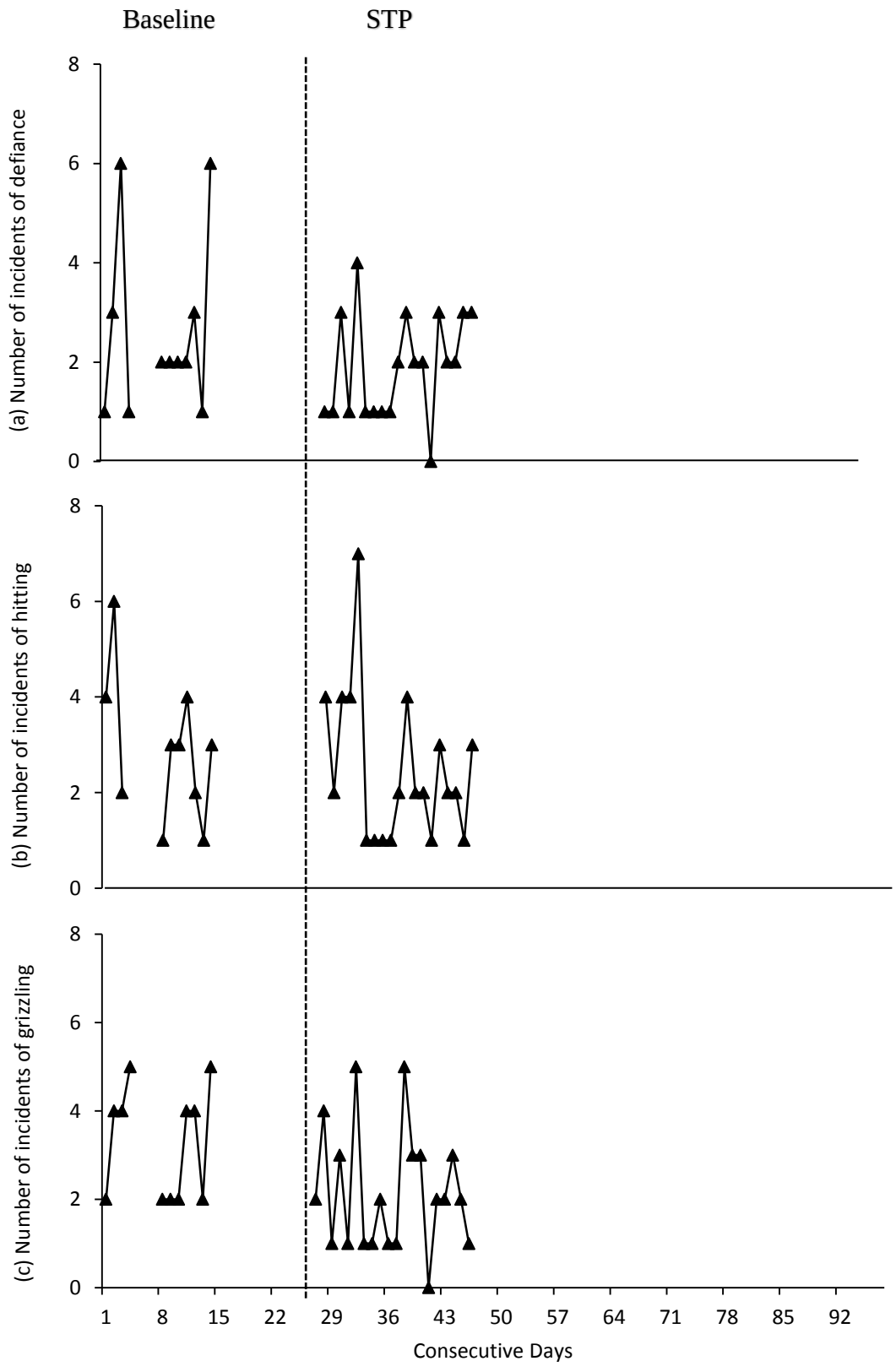
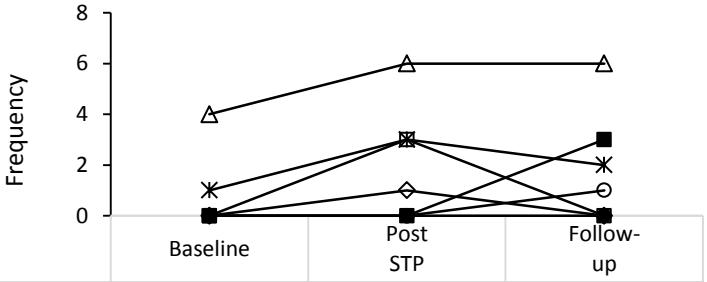


Figure 16. Number of incidents of (a) hitting, (b) defiance, and (c) grizzling recorded by Parent 3 across the experimental conditions. *Note.* The parent continued attending but discontinued recording the child's behaviours after the fourth session

Child-led play observations. Figure 17 and Figure 18 show the results of Parent 3 and Child 3, respectively, on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up.

Baseline. At baseline, Child 3 chose to play with the building tools and guns. Parent 3 asked few *information questions* and gave a *reflective statement*, while other responses were not evident, including *commands*, *praise* and *behaviour descriptions*. Child 3 showed high levels of compliance.



	Baseline	Post STP	Follow-up
Behavioural Descriptions	0	1	0
Reflective Statement	1	3	2
Information Questions	4	6	6
Unlabeled Praise	0	0	1
Labeled Praise	0	0	0
Indirect Commands	0	3	0
Direct Commands	0	0	3

Figure 17. Results of Parent 3 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Post-intervention. At post-intervention, Child 3 chose to play with guns and pretended to be a policeman. Parent 3 asked more *information questions* (i.e., deteriorated), gave more *indirect commands* (i.e., deteriorated), gave more *reflective statements* and made more *behavioural descriptions* than she had in baseline, while *directive commands*, *labelled* and *unlabelled praise* were not evident. Child 3 showed high levels of compliance and answering rates (i.e., improvement).

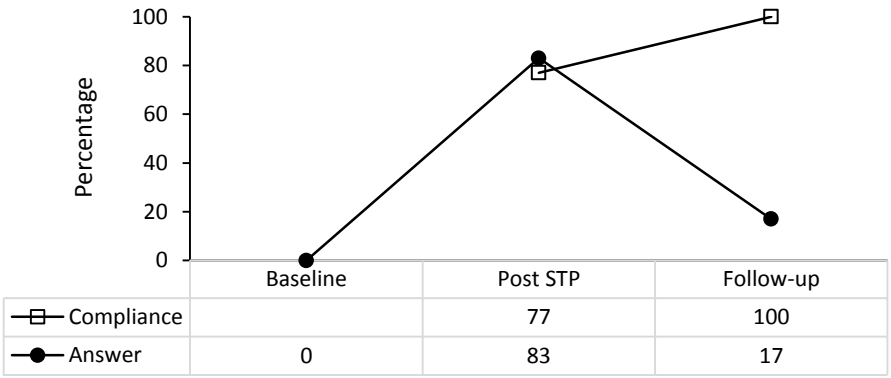
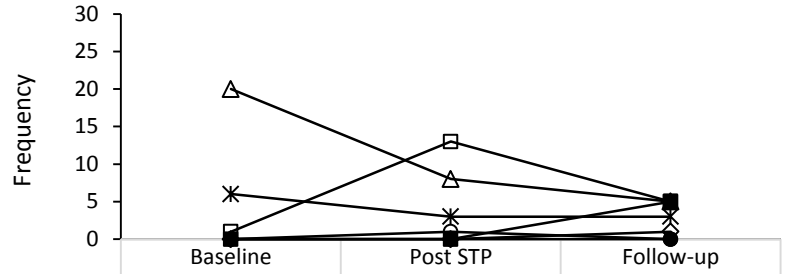


Figure 18. Results of Child 3 on DPICS coding of video-tapes taken under the child-led play segments at baseline, post-intervention, and follow-up

Follow-up. Child 3 chose to play with guns and pretended to be a policeman as he did in post-intervention. Parent 3 gave more *direct commands* (i.e., improvement); asked more *information questions* (i.e., deteriorated); gave *unlabelled praise* (i.e., deteriorated), made more *reflective statements* and than she had in baseline, while *indirect commands*, *labelled praise* and *behavioural descriptions* were not evident. Child 3 showed higher levels of compliance (i.e., improvement) but lower levels of answering rate (i.e., deteriorated) compared to baseline.

Parent-led play observation. Figure 19 and Figure 20 show the results of Parent 3 and Child 3, respectively, on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention and follow-up.

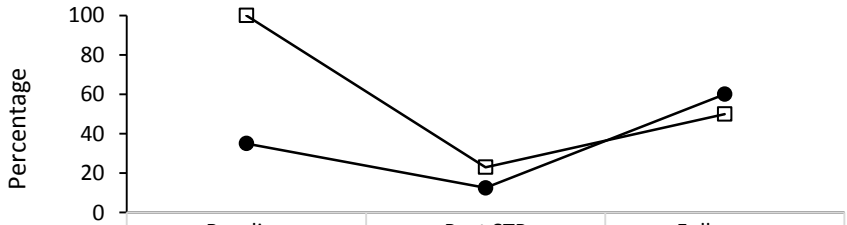
Baseline. At baseline, Parent 3 directed her son to play with medical kits with her, followed by playing with the toy kitchen. During the segment, Parent 3 predominantly asked *information questions*, made few *reflective statements* and gave an *indirect command*, while other responses were not evident. Child 3 showed high levels of compliance but low levels of answering rate.



	Baseline	Post STP	Follow-up
Behavioural Descriptions	0	0	1
Reflective Statements	6	3	3
Information Questions	20	8	5
Unlabeled Praise	0	1	0
Labeled Praise	0	0	0
Indirect Commands	1	13	5
Direct Commands	0	0	5

Figure 19. Results of Parent 3 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention and follow-up

Post-intervention. At post-intervention, Parent 3 instructed her son to play with the medical kits with her. During the segment, Parent 3 asked fewer *information questions* (i.e., improvement); gave more *unlabbeled praise* (i.e., deteriorated), gave more *indirect commands* (i.e., deteriorated) and gave fewer *reflective statements* than she had in baseline, while other resposnses were not evident. Child 3 showed lower levels of compliance and answering rates (i.e., deteriorated) compared to baseline.



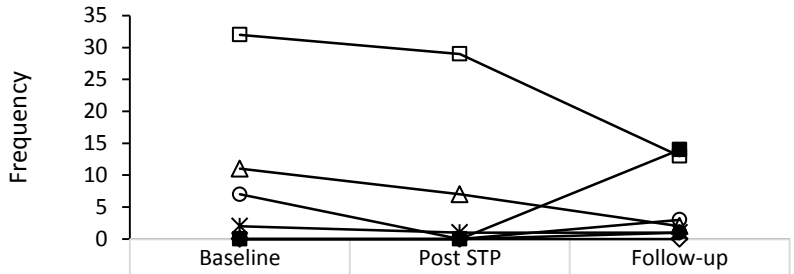
	Baseline	Post STP	Follow-up
Compliance	100	23	50
Answer	35	12.5	60

Figure 20. Results of Child 3 on DPICS coding of video-tapes taken under the parent-led play segments at baseline, post-intervention and follow-up

Follow-up. At follow-up, Parent 3 directed her son to draw. Parent 3 asked fewer *information questions* (i.e., improvement), gave more *direct commands* (i.e., improvement), as well as *indirect commands* (i.e., deteriorated), while she made more *behaviour descriptions* and gave fewer *reflective statements* than she had in baseline. Child 3 showed higher levels of answering rate (i.e., improvement) but lower levels of compliance (i.e., deteriorated) compared to baseline.

Clean-up observation. Figure 21 and Figure 22 show the results of Parent 3 and Child 3, respectively, on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention and follow-up.

Baseline. At baseline, Parent 3 predominantly gave *indirect commands* followed by *information questions*, *unlabelled praise* and *reflective statements*, while other responses were not evident. Child 3 showed low levels of compliance and answering rate.

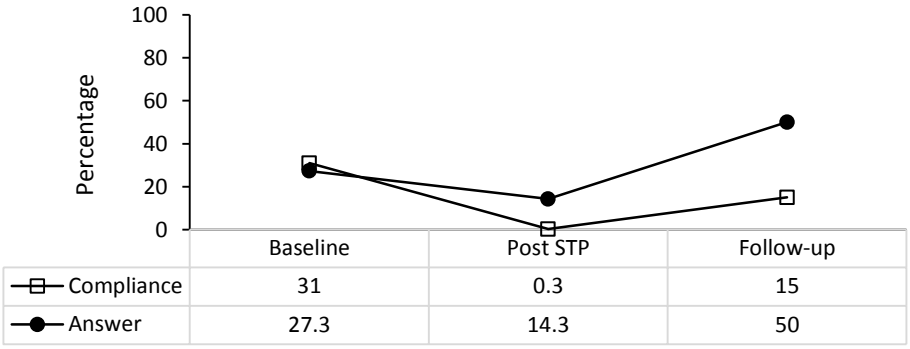


	Baseline	Post STP	Follow-up
Behavioural Descriptions	0	0	0
Reflective Statements	2	1	1
Information Questions	11	7	2
Unlabeled Praise	7	0	3
Labeled Praise	0	0	1
Indirect Commands	32	29	13
Direct Commands	0	0	14

Figure 21. Results of Parent 3 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention and follow-up

Post-intervention. At post STP, Parent 3 gave fewer *indirect commands* (i.e., improvement), asked fewer *information questions* (i.e., improvement) than she had in

baseline, while other responses were not evident, except, a *reflective statement*. However, Child 3 showed lower levels of compliance and answering rates (i.e., deteriorated) compared to baseline.



	Baseline	Post STP	Follow-up
Compliance	31	0.3	15
Answer	27.3	14.3	50

Figure 22. Results of Child 3 on DPICS coding of video-tapes taken under the clean-up segments at baseline, post-intervention and follow-up

Follow-up. At follow-up, Parent 3 made more *direct commands* and gave more *labelled praise* (i.e., improvement) while she gave fewer *indirect commands*, asked fewer *information questions* and gave fewer *unlabelled praise* (i.e., improvement) than she had in baseline. Child 3 showed higher levels of answering rate but lower levels of compliance compared to baseline.

Table 11

Scores of Family 3 on the Standardised Measures across Experimental Conditions

Measures	Baseline	Post-	Follow-up
ECBI-Parent Intensity score	**139** (**62**)	119 (56)	115 (55)
ECBI-Parent Problem score	**15** (**60**)	2 (43)	0 (41)
PS Total Score	3.3	2.3	2.1
JPSCS Total Score	32 (16)	36 (34)	38 (54)
SCRS-Parent Total Self-Control Score	120	118	97
SCRS-Teacher Total Self-Control Score	103	100	105
SDQ-teacher Total Difficulties Score	1	2	3
SDQ-teacher Total Strengths Score	7	7	**5**

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denote clinically significance level. JPSCS data in parentheses are percentile scores. Scores in clinically significant levels as well as borderline were shown in bold. Lower scores in ECBI, SDQ-Difficulties score, SCRS and PS indicate improvement in child behavioural problems and parenting style, respectively. Higher scores in JPSCS and SDQ-Strengths score indicate improvement in child self-concept and self-contol, respectively.

Child behaviour and parent functioning. Table 11 displays scores of Family 3 on the standardised measures across experimental conditions. At baseline, the mother's reports of the child's behavioural problems on the ECBI *Intensity* and *Problem* scales were in clinically significant levels. Child 3's JPSCS score was in the classification of *poor* self-concept. The teacher's rating on the *Difficulties* and *Strengths* scales were in non-clinical levels as per SDQ. Both parent and teacher's scores of the child's self-control remained in the normative range as per SCRS, however, decreasing score on the parent's rating indicated higher levels of child's self-control, which was not shown on the teacher's rating.

After the intervention, Parent 3's rating on the *Intensity* and *Problem* scales were in normative range per ECBI. The child's score on the JPSCS was in the classification of *moderate positive* self-concept. The parent and teacher's reports of the child's self-control on SCRS and the teacher's rating on the *Difficulties* and *Strengths* scales on SDQ remained in the normative range. At follow-up, Parent 3's rating on the *Intensity* and *Problem* scales were in the normative range as per ECBI. The child's score on the JPSCS was in the classification of *moderate positive* self-concept. The parent and teacher's scores on the

SCRS did not show changes in clinical levels, which scores remained in the normative range. While there was no changes in clinical levels on the teacher's rating on the *Difficulties* scale as per SDQ, the teacher's report on *Strengths* scale changed to the borderline range.

Family 4. There were 10 sessions of STP, and Parent 4 attended three out of 10 sessions as she dropped out after the third session. The mother and son participated in the baseline video observation.

Daily behaviour measures. The mother (Parent 4) nominated two behavioural problems for the *Daily Behaviour Measures* as follows: (a) non-compliance (meaning not following her instructions) and (b) temper-tantrums (meaning shouting, screaming, and yelling at her). Parent 4 reported on 13 out of 30 possible days which is equal to a 43% completion rate. She discontinued the study after the third STP session. At baseline, Child 4 showed moderate levels of noncompliance and temper-tantrums. After the first STP session, as shown in Figure 23 (P.119), while both behaviours increased, a decreasing trend in both behaviours was evident.

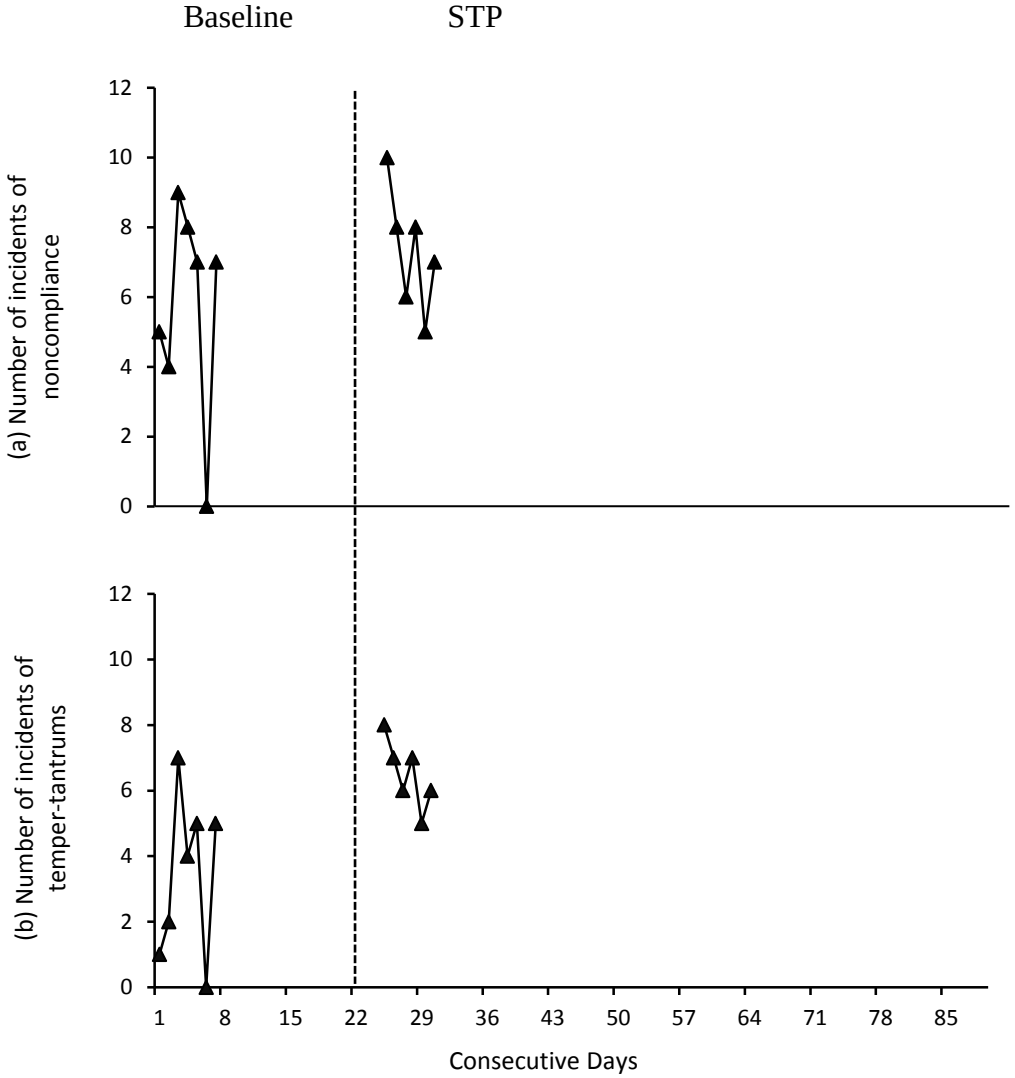
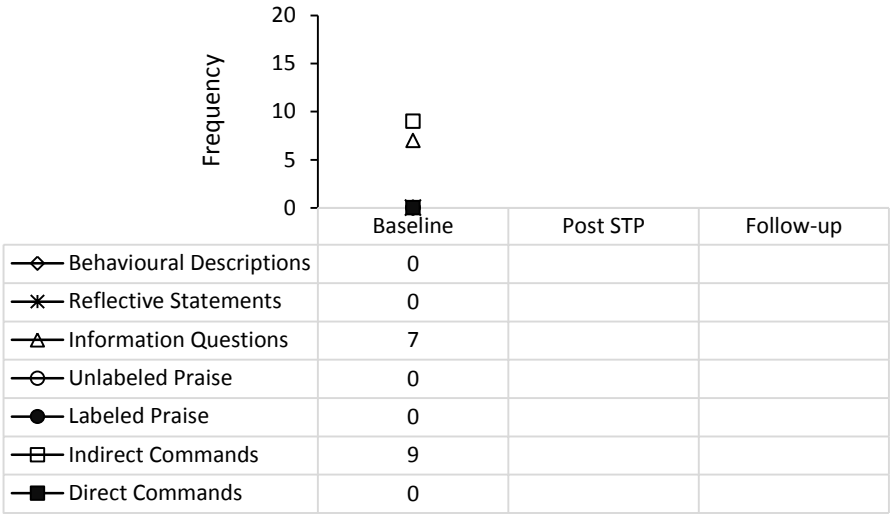


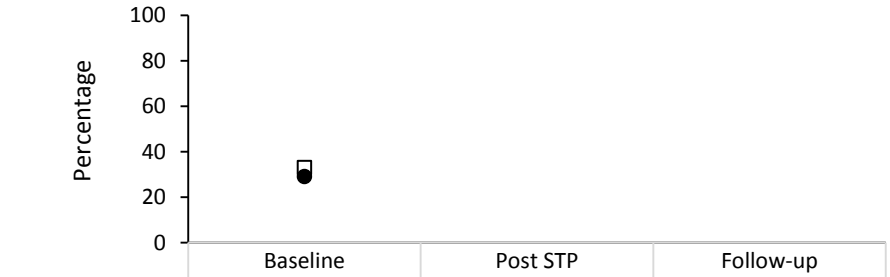
Figure 23. Number of incidents of (a) non-compliance, and (b) temper-tantrums recorded by Parent 4 across the experimental conditions. *Note.* STP=Level-4 Standard Positive Parentin Programme. Parent 4 attended three sessions but did not record the child's behaviour after the third session

Child-led play observations. Figure 24 and Figure 25 show the results of Parent 4 and Child 4, respectively, on DPICS coding of video-tapes taken under the child-led play segment at baseline, as Parent 4 discontinued the study after the third STP session.



	Baseline	Post STP	Follow-up
Behavioural Descriptions	0		
Reflective Statements	0		
Information Questions	7		
Unlabeled Praise	0		
Labeled Praise	0		
Indirect Commands	9		
Direct Commands	0		

Figure 24. Results of Parent 4 on DPICS coding of video-tapes taken under the child-led play segment at baseline

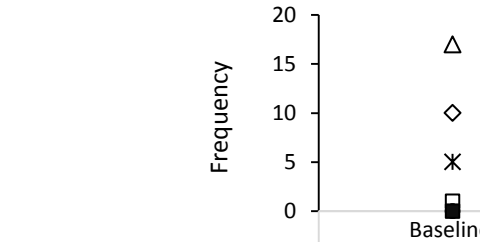


	Baseline	Post STP	Follow-up
Compliance	33		
Answer	29		

Figure 25. Results of Child 4 on DPICS coding of video-tapes taken under the child-led play segment at baseline

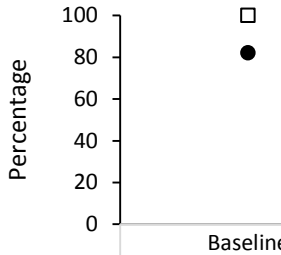
Baseline. During the child-led play segment, Child 4 chose to play with the building blocks and Parent 4 did not pay attention to the child or his play. Parent 4 predominantly gave *indirect commands* and asked *information questions*, while other responses were not evident. Child 4 showed low levels of compliance and answering rate.

Parent-led play observations. Figure 26 and Figure 27 show the results of Parent 4 and Child 4, respectively, on DPICS coding of video-tapes taken under the parent-led play segment at baseline, as Parent 4 discontinued the study after the third STP session.



	Baseline	Post STP	Follow-up
Behavioural Descriptions	10		
Reflective Statements	5		
Informations Questions	17		
Unlabeled Praise	0		
Labeled Praise	0		
Indirect Commands	1		
Direct Commands	0		

Figure 26. Results of Parent 4 on DPICS coding of video-tapes taken under the parent-led play segment at baseline



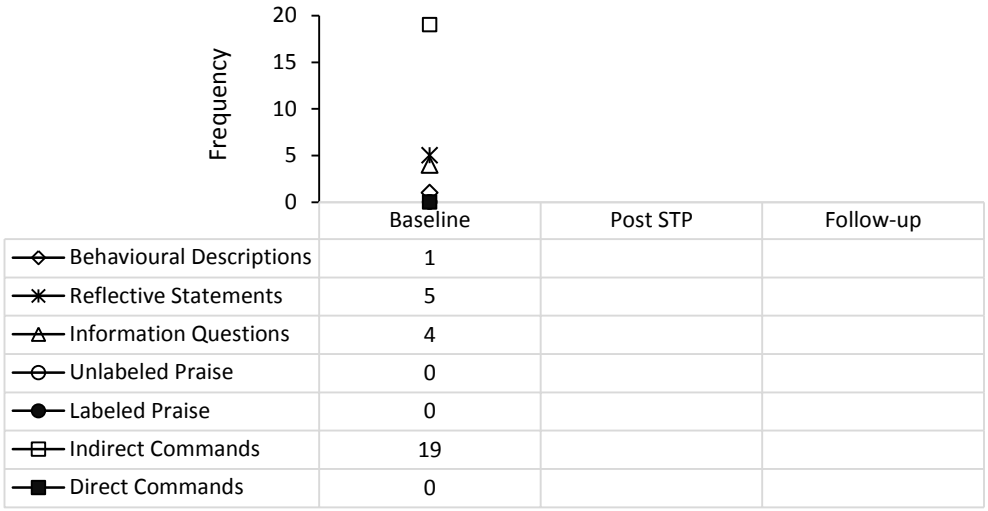
	Baseline	Post STP	Follow-up
Complaince	100		
Answer	82		

Figure 27. Results of Child 4 on DPICS coding of video-tapes taken under the parent-led play segment at baseline

Baseline. During the segment, Parent 4 directed her child to play with the dolls' house and the ambulance. Parent 4 predominantly asked *information questions* followed by

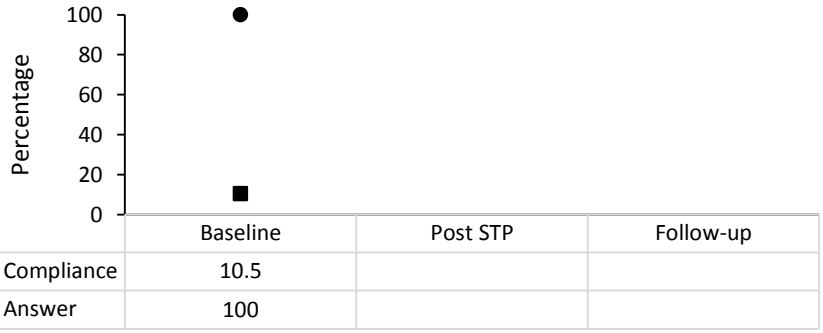
behavioural descriptions, while she gave few *reflective statements* and made few *indirect commands*. Child 4 showed high levels of compliance and answering rate.

Clean-up observation. Figure 28 and Figure 29 show the results of Parent 4 and Child 4, respectively, on DPICS coding of video-tapes taken under the clean-up segment at baseline.



	Baseline	Post STP	Follow-up
Behavioural Descriptions	1		
Reflective Statements	5		
Information Questions	4		
Unlabeled Praise	0		
Labeled Praise	0		
Indirect Commands	19		
Direct Commands	0		

Figure 28. Results of Parent 4 on DPICS coding of video-tapes taken under the clean-up segment at baseline



	Baseline	Post STP	Follow-up
Compliance	10.5		
Answer	100		

Figure 29. Results of Child 4 on DPICS coding of video-tapes taken under the clean-up segment at baseline

Baseline. During the segment, Parent 4 predominantly gave *indirect commands*, asked few *information questions*, gave few *reflective statements* and made a *behavioural description*, while other responses were not evident. Child 4 showed high levels of answering rate but low levels of compliance.

Table 12

Scores of Family 4 on the Standardised Measures across Experimental Conditions

Measures	Baseline	Post-	Follow-up
ECBI-Parent Intensity score	**164** (**69**)	-	-
ECBI-Parent Problem score	**19** (**65**)	-	-
PS Total Score	3.0	-	-
JPSCS Total Score	34 (24)	-	-
SCRS-Parent Total Self-Control Score	159	-	-
SCRS-Teacher Total Self-Control Score	114	-	-
SDQ-teacher Total Difficulties Score	**19**	-	-
SDQ-teacher Total Strengths Score	**0**	-	-

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denote clinically significance level. JPSCS data in parentheses are percentile scores. Scores in clinically significant levels as well as borderline were shown in bold. Lower scores in ECBI, SDQ-*Difficulties* score, SCRS and PS indicate improvement in child behavioural problems and parenting style, respectively. Higher scores in JPSCS and SDQ-*Strengths* score indicate improvement in child self-concept and self-contol, respectively. – =data was not collected as Family 4 discontinued the study.

Child behaviour and parent functioning. Table 12 displays scores of Family 4 on the standardised measures across experimental conditions. At baseline, the mother rated his son's behaviour problems in clinically significant levels on the ECBI *Intensity* and *Problem* scales. Child 4's JPSCS score was in the classification of *watch-list* self-concept. The teacher-reported child's problematic behaviour and strengths were in the abnormal range on SDQ. The parent's and teacher's scores of the child's self-control were within the normative range on SCRS.

Within-intervention analysis. Within-intervention analyses was conducted to determine changes in child behaviour, if any, following the specific content taught to the parent in each intervention sessions. The relationship between the specific strategies taught, in CPRT and STP, and the child's targeted behaviours, as per *Daily Behaviour Measure*, were explored using a session-by-session analysis at individual level. As the strategies taught in each intervention were not measured individually through observation, the changes in the child's targeted behaviours after every single intervention session were assumed to be related to the strategies or contents taught in each session rather than the direct impacts. The results were discussed as follows.

In the first session, the CPRT parents were taught to use the *be-with attitude* and *reflective statements* to respond to their children. This was followed by an immediate decrease in the number of incidents of non-compliance of Child 1 and Child 2 in comparison to their baseline (Figures 2, p.94 and Figure 9, p.103). Moreover, the number of incidents of non-compliance of Child 1 was recorded as it's lowest. After the be-with attitude and *reflective statements* were taught to Parent 2, the number of temper-tantrums and hitting incidents of Child 2 decreased markedly and remained low for several weeks (Figure 9). However, noticeable changes in interruptions and switching-offbehaviour of Child 1 were not shown following the first CPRT session.

In the second CPRT session, the parents were taught the basic principles of CCPT. Following that, there was a noticeable reduction in switching-off behaviour of Child 1, and non-compliance and temper-tantrums of Child 2 compared to their baseline (Figures 2 and Figure 9). The number of interruptions of Child 1 reduced markedly compared to the previous session. In addition, Child 1 remained a 100% of compliance after the second CPRT session as recorded by his mother. However, no noticeable changes in the number of

incidents of interruptions of Child 1 (Figure 2, p.94) as well as the number of incidents of hitting of Child 2 (Figure 9, p.103), as recorded by their mothers, following Session 2.

In the third CPRT session, the parents were taught the *play session dos and don'ts* and asked to conduct the first child-led play sessions at home, and it was followed by a further decline in switching off behaviour of Child 1 (Figure 2). In addition, Child 1 stopped his switching-off behaviour following the first child-led-home-play session. While Child 1 retained his gain in compliance after the first CPRT session (Figure 2), a slight reduction in interruptions was noted. All nominated behavioural problems of Child 2 were not recorded by his mother after Session 3.

In the fourth CPRT session, the parents were taught the *A-C-T limit setting* strategy and it followed by zero incidents of switching-off and non-compliance of Child 1 (Figure 2). While the number of temper-tantrums of Child 2 reduced further after the Session 4, no noticeable change was recorded on the number of incidents of non-compliance and hitting (Figure 9). On the other hand, the number of interruptions of Child 1 increased largely compared to the previous session (Figure 2).

In the fifth CPRT session, the parents were taught the rationale of A-C-T Limit Setting strategy, including the implications of *precise messages* and it followed by a considerable reductions in all nominated behaviours of Child 2, including non-compliance, temper-tantrums and hitting incidents (Figure 9). These behaviours were recorded at their lowest levels across the experimental conditions. Moreover, the number of switching-off incidents of Child 1 remained at zero and the number of interruptions of Child 1 reduced markedly as compared to the previous sessions (Figure 2). However, the number of non-compliance incidents of Child 1 increased slightly after the fifth CPRT session (Figure 2). Overall, most of the nominated behavioural problems of both CPRT children were recorded at very low

levels if not the lowest after the rationale of *A-C-T limit setting* strategy, through the use of *precise message*, were taught to their parents.

In the sixth CPRT session, the parents were taught the *choice-giving* strategies (e.g., positive choices) and it was followed by low to zero levels of switching-off and interruption incidents of Child 1 (Figure 2, p.94). On the other hand, marked increases in the number of non-compliance incidents of both children to their highest levels (Figure 2 and Figure 9) were recorded following Session 6. Moreover, a considerable increase in temper-tantrums and hitting incidents of Child 2 was recorded compared to his gains in the previous session (Figure 9, p.103).

In the seventh CPRT session, the parents were taught the *esteem-building* responses and it was followed by low to zero levels of switching-off and interruption incidents in Child 1 (Figure 2) and a further decline in the number of non-compliance incidents of Child 2 from the previous session (Figure 9). On contrary, the number of non-compliance incidents of Child 1 (Figure 2) and the number of temper-tantrums of Child 2 (Figure 9) were recorded at their highest across the intervention phase, while no noticeable change was recorded in the number of incidents of hitting in Child 2 (Figure 9).

In the eighth CPRT session, the parents were taught the *encouragement* strategies and it was followed by zero levels of switching-off incidents and low levels of interruptions in Child 1 (Figure 2); a reduction in the number of temper-tantrums of Child 2 was also noted (Figure 9). While a reduction in the number of non-compliance incidents of Child 1 was evident, there was a slight increase in the number of non-compliance incidents of Child 2. No noticeable change in the number of hitting incidents of Child 2 was recorded.

In the ninth CPRT session, the parents were taught the *choice-giving as consequences* and it was followed by a further decline in all nominated behavioural problems of Child 1, which were recorded at their lowest levels (Figure 2). While no noticeable change in the

number of non-compliance incidents and temper-tantrums of Child 2 were noted, there was a marked increase in the number of hitting incidents of Child 2, which was at its highest level across the intervention phase (Figure 9, p.103).

In the tenth CPRT session, the parents were taught the *structured doll play* technique and it was followed by zero levels of all nominated behavioural problems of Child 1 (Figure 2, p.94). In addition, a further reduction was noted in the number of hitting and non-compliance incidents of Child 2 (Figure 9). The number of non-compliance incidents of Child 2 reached its lowest once again. However, no noticeable change in the number of temper-tantrums of Child 2 was noted (Figure 9) in comparison to the previous session.

Due to the lack of data from the STP parents, the inspection of the relationship between specific contents of STP and the recorded child behaviours immediately following each session was carried out only on the second, third and fourth STP sessions.

In the second session of the STP, the parents were taught the *descriptive praise* and *quality time* as positive parenting practices. It was followed by a noticeable reduction in defiance of Child 3, however no noticeable change in the number of incidents of grizzling was recorded (Figure 16, p.111) in Child 3. However, an increase in the number of non-compliance incidents and temper-tantrums of Child 4 (Figure 23, p.119) and hitting incidents of Child 3 (Figure 16) was noted following the second STP session. Overall, no positive changes in the child's nominated behavioural problems were recorded, except defiance in Child 3, following the second STP session.

In the third STP session, the parents were taught the *clear instruction* and *1-2-3 time-out* strategies for managing misbehaviour. It was followed by a considerable reduction in the number of hitting and defiance incidents of Child 3 (Figure 16). Apart from that, no noticeable change in the number of grizzling incidents of Child 3 was recorded. Parent 4

dropped out after the third STP session and did not provide any record of her child's behavioural problems.

In the fourth STP session, Parent 3 was taught the *compliance routine*. This session was carried out at the participant's home; Parent 3 was asked to practise the *compliance routine* with her son while the intervention provider observed. A noticeable reduction in the number of grizzling incidents of Child 3 (Figure 16, p.111) was noted following this session. While no noticeable change in the number of defiance incidents was evident in Child 3, a slight increase in the number of hitting incidents of Child 3 was recorded (Figure 16).

Social validity. The social validity of the present study was evaluated using parent comments and expression at the conclusion of the intervention, at post-interevntion and follow-up sessions. Parents from both interventions made comments about the intervention they received. At post-intervention, Parent 1 reported that the CPRT "has helped me immensely, especially to make me stop and take stock of my feelings – I feel I have become a much better parent". At follow up, Parent 1 said "I feel I have become a better parent, more calm and able to deal with situations easily." Parent 1 also reported that she has been "more in control without being controlling" since she participated in CPRT.

At the final session of the CPRT, Parent 2 said that "I have changed from a controlling mother to a mother who is more able to understand my children and their struggles" and "I notice that I have not been angry since I joined the training". Parent 2 was so happy that her relationship with her husband has improved and they were more open with each other about their own feelings. Parent 2 was pleased with her husband's commitment on the training as he was telling her that "that is a waste of time" after his attended the second session of CPRT. After the video-recorded interactional session of the mother-child dyad at follow-up, Parent 2 reported that "I don't even realize that I was using the skills! It was way easier to let him lead than telling him what to do!"

Parent 1 and Parent 2 reported on their follow-up sessions that they continued to use the play therapy skills after the conclusion of the CPRT. In addition, Parent 1 and Parent 2 emphasised that by using *choice-giving as consequences,* they are able to control their own emotions and therefore able to help their children to be responsible for their own behaviour. Both parents said that they no longer needed to use their authority to control their children's behaviours which made them felt better about themselves as parents.

Parent 3 who attended the STP reported at the post-intervention that participating in the STP has been a very positive experience for her and her family. Parent 3 also reported that Child 3 "is now getting himself dressed and eager to get to kindy", as all this was a battle before she participated in the intervention. At follow up, Parent 3 said that "I recommended one of my friends in England, who is having difficulty in managing her son's behaviour to attend the positive parenting programme." She also reported that she was very happy to find out from the teacher that her son might be a gifted child, as this reassured her that she has done the right things for him. At the meantime, she also mentioned that she was happier and confident in parenting her children as she had has the skills.

Summary

Measures of parenting skills showed improvements for all the parents. All parents showed intended improvement of the intervention across all the interactional segments using the DPICS (Eyberg et al., 2009). Parents 1 and 2, who participated in CPRT, improved in most of the parental variables across segments, such as an increased in *reflective statements* and *behavioural descriptions,* and a reduction in *commands* and *information questions*. Parent 3, who participated in STP, reduced *information questions,* during parent-led and clean-up segments, and *indirect commands* and increased *direct commands,* during clean-up segment. Regardless of interventions, the parents all rated themselves as improved on the PS (Arnold et al., 1993).

Direct outcome measures of the children's behaviour showed improvements for Child 1 and Child 2, whose parents participated in CPRT, but not for Child 3, whose parent participated in STP. With the exception of the child-led play segments, visible differences in behaviour were observed between the two CPRT children and the one STP child across the parent-led play and the clean-up segments using the DPICS (Eyberg et al., 2009). The children in the CPRT group improved in their compliance and answering rates during both of the interactional segments, while the compliance rate of the STP child (Child 3) deteriorated. In addition, a decreasing trend on the nominated behavioural problems of the CPRT children were recorded within the intervention phase, but this was not evident in the STP child.

During follow-up, all of the children retained their post-intervention gains in their nominated behavioural problems, as recorded by their parents, as well as their self-concept. For example, Child 1 retained his gains in all his nominated behavioural problems, with only one to two incidents of interruptions, non-compliance and switching-off were recorded within the 2-week follow-up phase. All nominated behavioural problems of Child 2, including non-compliance, temper-tantrums and hitting incidents, were considerably low at follow-up as compared to his baseline. Similarly, all nominated behavioural problems of Child 3, including hitting, defiance and grizzling, reduced to lower levels at follow-up. Regardless of the type of interventions the parents received, all of the children rated themselves higher on the JPSCS (Joseph, 2004). Overall, the children's scores were in the ranges of *positive* of self-concept at post-intervention as well as follow-up. For example, the CPRT children rated themselves in the classification of *high positive* self-concept and the STP child rated himself in the classification of *moderate positive* self-concept.

The parent's measures of child behaviour on the standard measures showed improvement in all children. Regardless of interventions, all children were reported as improved in their behavioural problems, from clinical levels to non-clinical levels, on ECBI

Problem scale (Eyberg & Pincus, 1999) at post-intervention and follow-up, while a marked decrease in *Intensity* score was found across all children. Among them, Child 1 and Child 3 showed clinically significant change on their behaviour intensity on *Intensity* scale at post-intervention. However, only Child 3's *Intensity* score remained in non-clinical levels at follow-up. All children were rated by their parents in normative ranges for their self-control on SCRS (Kendall & Wilcox, 1979) across phases; the scores indicated improvement in self-control across all children.

All children were rated by their teachers in the normative range for their behavioural difficulties and self-control on SDQ (Goodman, 1997) and SCRS (Kendall & Wilcox, 1979), respectively at baseline, post-intervention and follow-up. The teachers' scores on the *Difficulties* scale as per SDQ revealed a decreasing trend in difficult behaviour of both CPRT children across phases, while a reversing trend was found in Child 3's *Difficulties* score. At baseline, the teachers scored Child 2 and Child 3 in normative ranges for their strengths on SDQ, while Child 1 was rated by his teacher in the borderline range. No change was found on teacher's rating of the child's strengths at post-intervention but follow-up; Child 1's score increased to the normative range but Child 3's score deteriorated to the borderline range. While all teachers rated the children in non-clinical levels on SCRS for their self-control, improvement in terms of score was only noted in Child 2.

Table 13

Strategies Taught in Each Session and Its Corresponding Outcome Across Children.

S	CPRT	C1	C2	STP	C3	C4
1	Be-With attitude & Reflection	↓NC	↓NC ↓TT ↓H	The causes of child behaviour problems	No record	No record
2	Basic principles of CPT	×NC ↓IT ↓SO	↓TT	Descriptive praise & quality time	↓DF ↑H	↑NC ↑TT
3	Play sessions procedures, dos & don'ts	↓SO	No record	Clear instructions & "1-2-3" time-out	↓DF ↓H	Drop-out
4	A-C-T limit setting	×SO ↑IT	↓TT	Compliance routine	↓GZ ↑H	
5	The rationale of A-C-T limit setting	× SO ↑NC	↓NC ↓TT ↓H	No new strategies were taught	No record	
6	Choice-giving	×SO ↓IT ↑NC	↑NC ↑TT ↑H	No new strategies were taught	No record	
7	Esteem-building	×SO ↓IT ↑NC	↓NC ↑TT	No new strategies were taught	No record	
8	Encouragement	×SO ↓NC ↓IT	↓TT ↑NC	No new strategies were taught	No recorde	
9	Choices as consequences	×NC ×IT ×SO	↑H	Planned activities for 'high-risk-situations'	No record	
10	Structured doll play	×NC ×IT ×SO	↓NC ↓TT	Practice three planned activities	No record	

Note. S=Session; C=Child; ×=no incident; ↓=reduction; ↑= increase; CPRT=Child-Parent Relationship Therapy; STP=Standard Level-4 Positive Parenting Programme; NC=non-compliance, IT=Interruptions; SO=switching-off; TT=Temper-Tantrums; H=Hitting.

In terms of parental engagement and homework compliance, Parent 1 and 2, who participated in CPRT, showed high levels of homework compliance, while Parent 3, who participated in STP, showed low levels of homework compliance. For instance, the CPRT parents (Parent 1 and 2) completed more than 90% of the daily assignment, while the STP

parent (Parent 3) completed less than half of the assignment. Moreover, Parent 1 and 2 attended all CPRT sessions, while Parent 3 attended eight out of 10 STP sessions and Parent 4 dropped out after the third STP. Overall, high attendance rates were found on the parents who completed the interventions.

Discussion

In this section, the results of two interventions, CPRT and STP, on the families of children with behavioural problems are discussed. The outcomes of the families, in terms of attendance, homework compliance, observed parental responses as well as recorded child behaviour following each intervention session are highlighted to represent each family and each intervention individually. As single-subject design was used, direct comparison between participants or between interventions was not attempted; the findings and discussion were considered as exploratory rather than directional.

In terms of attendance, the parents who completed the intervention showed an overall high attendance rate. In the current study, attendance is defined as the percentage of intervention sessions attended by the families, to which they were assigned. A high attendance rate by the parents who participated in behavioural intervention was documented in some studies. For example, 80% and 89% attendance rates were found in the parents who participated in a 20-session IY-PT (Lees & Ronan, 2008) and a four-session Triple P, respectively (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). The two STP parents who took part one of them dropped out compared to none of the CPRT parents. According to Koerting et al. (2013), parent, therapist and programme are three contributing factors for drop-out among parents in parenting programmes. In terms of the programme's factors, these results indicate that there is possibly a difference in engagement between the two programmes and this should be further investigated. The attendance rate of the parents who

participated in CPRT in the current study was encouraging; thus it was studied in further depth in the following study.

In terms of homework compliance, the parents in both interventions did not complete all of the homework assignments, as predicted in a survey of homework use among couples and family therapists (Dattilio, Kazantzis, Shinkfield, & Carr, 2011). The two CPRT parents who took part showed higher overall levels of homework completion than the two STP parents. This result indicates that there is possibly a difference in homework compliance between parents in different programmes.

In terms of observed parental responses, the parents in both interventions improved in some taught strategies during the parent-child play sessions at post-intervention and follow-up. The two CPRT parents who took part showed more improvement in taught strategies than the two STP parents. For instance, the CPRT parents improved in four out of four taught strateges, including an increase in *reflective statements* and *behavioural descriptions* and a decrease in *commands* and *information questions*, during the child-led play segment at post-intervention and follow-up. These gains were mostly generalised in the parent-led play segment as well as the clean-up segment. The STP parent who completed the intervention, improved in one to two out of five taught strategies during the parent-led play segment at post-intervention and follow-up while she improved in four out of five taught strategies during the clean-up segment at follow-up. This result indicates that there is possibly a difference in parents' skills acquisition across programmes and this should be further investigated.

Most of the parents' nominated child behavioural problems of both CPRT children reduced considerably within the first five CPRT sessions, although they were still showing some of the behavioural problems at the conclusion of the intervention. It is unrealistic to expect children to comply and behave at all times (Borrego & Urquiza, 1999 ; Stephenson &

Hanley, 2011). The findings suggested that there was a possible relationship between what the parents were taught during intervention sessions and changes in the parents' record of the child's nominated behavioural problems. However, these findings are contradicted by the findings of a single-subject study of the effectiveness of the IY-PT which suggested that "the negative behaviours are more resistant to initial treatment effects" (Lees & Ronan, 2008, p. 116). Overall, the positive findings on the child's nominated behaviours provide indications of the effectiveness of CCPT strategies taught in the first five CPRT sessions, including the *be-with attitude*, *reflective statements*, *behavioural descriptions*, *the A-C-T limit setting* and the rationale of *A-C-T limit setting*, in reducing the nominated behavioural problems of the CPRT children.

The relationship between the changes in parent and child responses within the intervention phase was explored through observations. The findings indicated a possible positive relationship between the observed parent responses and observed child responses. In addition to the considerable improvement in CCPT strategies among the two CPRT parents, noticeable improvements in the observed child responses were evident among the two CPRT children. Gains in specific CCPT strategies taught in CPRT, such as an increase in *behavioural descriptions* and *reflective statements*, were followed by an increase in the observed *child compliance*. On the other hand, STP Child 3, whose parent improved in some of the observed parent responses, such as increased *commands* and reduced *information questions*, deteriorated in his observed *compliance*. A recent study of moderators and mediators of outcomes within the IY-PT parenting programme suggested that "improvement in positive parenting is a key factor mediating change in child problem behaviour" (Gardner et al., 2010, p. 577).

In terms of family characteristics and programme success, Parent 1, the only single-mother who was without a tertiary degree in this study, completed the CPRT successfully.

She attended all the intervention sessions and completed more than 90% of her homework assignments. Moreover, Parent 1's observed parenting strategies and her son's observed behavioural problems improved noticeably. These findings were similar to those found in a study of a parent management for single high-risk mothers of children with ADHD which reported that all mothers attended and finished the programme (Lees & Ronan, 2008). Gardner and colleagues also (2010) suggested that a single-parent is as likely to improve following intervention as other parents. Bratton and Landreth (1995) found that a group format of FT was effective in improving the level of empathy and acceptance of single-parents toward their children and reducing the parents' perceptions of child problematic behaviour. Taken together, the results indicated that single-parents or parents with multiple risk factors, if they complete an intervention, can improve in their parenting skills and hence positively influence their children's behaviour.

On the other hand, some studies have indicated that single-parents and parents with low academic qualifications and social economic status are at high-risk of drop-out from parenting programmes and poor outcomes (Baker, Arnold, & Meagher, 2011; Lundahl, Risser, & Lovejoy, 2006; Nix, Bierman, & McMahon, 2009; Topham & Wampler, 2008) as compared to their counterparts. Previous literature has also suggested that parent marital status and education are likely to influence intervention outcomes (Kazdin, 1995; Webster-Stratton & Hammond, 1990). Nevertheless, neither the marital status nor the education levels of the single-mother, Parent 1, who participated in the CPRT, negatively impacted intervention outcomes. Moreover, Bratton and Landreth (1995) emphasised that FT is a method to help both single-parents and their children to achieve a healthy parent-child relationship, while offering emotional support which is needed by single-parents. The findings of Study 1 supported the idea that CPRT provides sufficient support for single-

parents, as well as parents with a lower level of educational achievement and social economic status; hence it could be a possible intervention for this population.

Limitations

Despite the encouraging findings, there were several limitations in the current study. First, the baseline phase of the children's targeted behaviours was of a predetermined length instead of being based on the achievement of the stability of the behaviours (Cooper et al., 1987). This was due to time constraints. In practical situations, delaying the start of the intervention until behavioural stability is achieved may result in the loss of participants or the loss of an initially positive relationship between the participants and the therapists. The parents might think that conducting the research is more important than helping them. A short baseline phase has been used in other studies involving parents. For example, a study of the effectiveness of parent management training has a four-day baseline interval (Lees & Ronan, 2008).

A second limitation of the current study was it did not employ a randomised multiple-baseline design which would have truly allowed each child or parent dyad to act as their own controls. A third limitation was that the six-month follow-up was somewhat short, so it limits the study of the maintenance of intervention gains. A fourth limitation was that the process and the fidelity of the delivery of each intervention were not measured. However, each intervention was delivered by the same intervention provider, according to the respective treatment manual and using the standard parents' workbooks, to ensure the content fidelity of each intervention was obtained. A fifth limitation was that all children from the four families were male. Therefore, further studies are needed to investigate the intervention outcomes on female children. A sixth limitation was that two different therapists were employed, which might have contributed to different intervention outcomes due to the differences in therapists' styles and characteristics. The seventh limitation was that the direct observation measure did

not capture all strategies taught in both interventions, thus it limits the study of the effect of each intervention on the parent's responses. The findings of the current study need to be interpreted with the above limitations.

Conclusion

Positive Parenting Programme is one of the predominant interventions for child behavioural problems, particularly in New Zealand; therefore it is important to understand the role CPRT might have as an alternative therapy. In regard to this, the findings of this single-subject study provide evidence of the possible effectiveness of CPRT in promoting high levels of parent engagement and increasing positive parenting skills while reducing child behaviour problems among two families of young children with behavioural problems. Of the two parents who took part in STP, one who completed the intervention showed high levels of attendance but low levels of homework completion; the STP child showed clinically significant change in his behaviour on parent rating.

Chapter 4: Rationale for the Adapted CPRT Model and Research Methods

Implications of the Results of Study 1

Evidence from Study 1 study suggested that CPRT leads to rapid changes in both parent skills and child behaviour and, at least in the pilot study, attendance, retention and outcome were better for this programme than STP. It was decided to investigate CPRT further with a particular examination of whether the gains observed early in the CPRT programme mean that a more rapid programme may be also effective. A quick improvement in problematic behaviours in the CPRT children and trends toward high attendance and engagement in the parents were evident in Study 1. These can be conceptualised as the sooner the parent-child relationship can be re-established, the faster a child obtains positive changes in behaviour, which may simultaneously increase the parent's retention in the therapy. The results of Study 1 provided an insight into how positive changes in child behaviour can occur early in a parenting programme. The timing of the positive changes fits the parents' expectation of a parenting programme for a quick fix of their children's behavioural or emotional problems (Garza, Watts, & Kinsworthy, 2007), even though changes should be carefully planned from a clinical standpoint. These hypothesised processes, if not the functional relationship, between the parent-child relationship, the child's behavioural improvement and the parents' retention are illustrated in Figure 30, p.140 and described as follows.

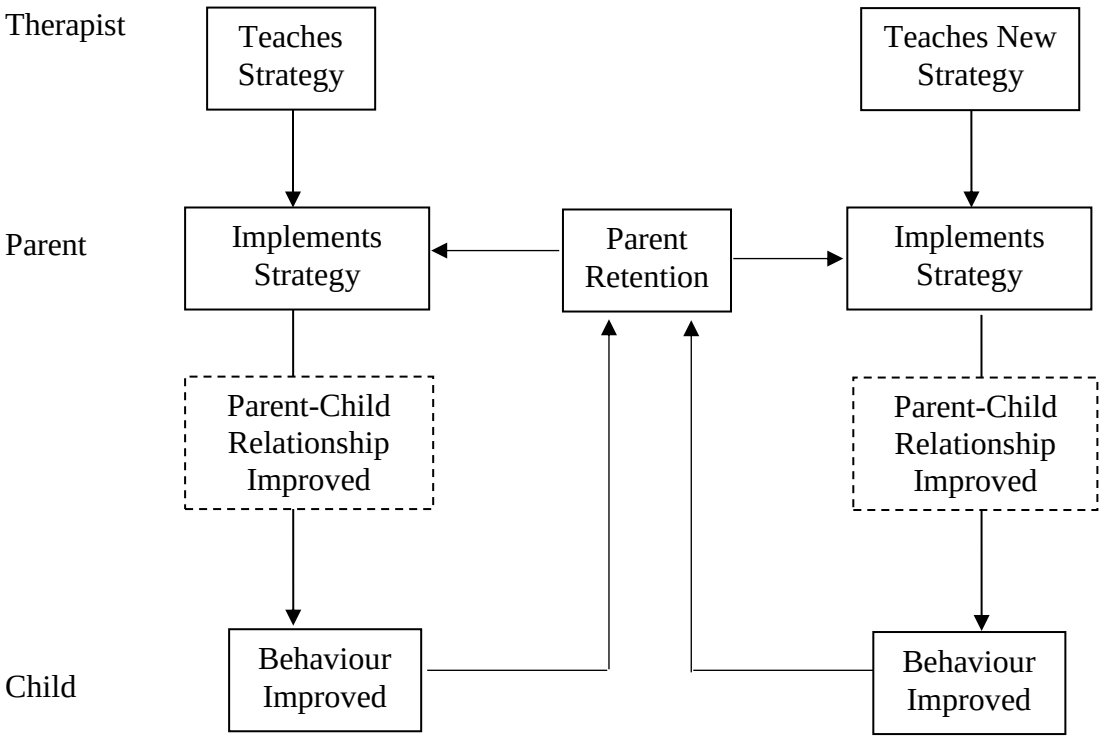


Figure 30. The interaction between the parents' implementation of strategies, the child's behavioural improvement and the parents' retention

Figure 30 illustrates that the parent's implementation of the CCPT strategies in the early sessions, which aims to improve the parent-child relationship through increased parental understanding and acceptance towards the child, may eventually reduce the child's problematic behaviour. The dynamic interaction between the three variables was proposed to occur in an ongoing manner under the following prospect. First, the parent enters intervention and learns CCPT principles and strategies to increase his or her understanding and acceptance of the child. Next, the parent implements the CCPT strategies and thus influences the parent-child relationship positively. Then, the child's behavioural regulation would be stimulated by the therapeutic parent-child relationship, which was conveyed using

the basic CCPT strategies. When the child's behaviour has improved, the parent is more likely to remain in the intervention and continue to learn and implement CCPT strategies to further establish the parent-child relationship and continue to facilitate the child in regulating his or her behaviour, and hence enhance positive behavioural changes in the child. This proposed model hypothesised that an intervention which could strengthen intervention gains in early sessions, including increased parent's competency in implementing the taught principles and strategies as well as improved child behaviour, might largely increase the parent's retention by heightening his or her enthusiasm for and confidence in the intervention. When these three variables interact in an ongoing manner, the effect of each variable in the proposed process is to interrelate with one another in a transactional manner to produce promising intervention outcomes. The proposed process is supported by the findings of two studies. For instance, Day et al., (2011) found that positive behavioural changes in the children during the early stage of intervention brought a sense of achievement in the parents, which helped to engage the parents in the Helping Families Programme. In a filial therapy study, Topham and Wampler (2008) reported that the parents who succefully attained the taught strategies during early intervention showed high levels of attendance.

Findings of Study 1 indicated that most of the children's behavioural problems as nominated by the parents reduced greatly within the first five CPRT sessions. The early positive change in a child's behaviour recognises a potential timing for sufficient gains in CPRT. It suggested that the length of CPRT can be potentially reduced by half without diminishing its effectiveness. Hypothetically, a 5-session intervention programme would be more cost-effective, if it could be shown to be effective. A shorter intervention which could produce intervention gains in early sessions may largely increase parents' confidence and retention, which ultimately reduce drop-out. For example, a shorter intervention might have

prevented Parent 4 from an early drop-out as it would have been less time demanding, while positive changes in child behaviour may have occurred sooner.

Studies have suggested that there is a relationship between parent participation and the duration of intervention. A study of recruitment and retention in a 4-session behavioural parenting programme for parents of preschoolers with behavioural and emotional problems indicated that 57% of parents, who refused to participate but returned the questionnaire, perceived parental intervention as time demanding (Heinrichs et al., 2005). In two recent studies, parent attendance has been found to decrease steadily over the length of a parental programme (Baker et al., 2011; Topham & Wampler, 2008). Therefore, in the light of the findings in Study 1, it would be ideal if the potential effectiveness of CPRT could be retained even when the number of the intervention sessions was to be reduced. If this is the case, a shorter version of CPRT would not only be more cost-effective and less time demanding, but is more likely to reduce some barriers in parents' enrolment, attendance and engagement, which may potentially enhance intervention gains.

Scott and Dadds (2009) recognised the need to promote engagement and diminish drop-out in parenting programmes, while Cornett and Bratton (2013) acknowledged that the 10-session CPRT may require a serious commitment from families owing to its length and the considerable level of parental involvement. Undoubtedly, parents' retention is one of the key factors in achieving the goals of an intervention. Therefore, retaining parents is not only as important as promoting promising outcomes in a parent intervention, but also as challenging as a longer one. The findings of Study 1 suggested that a 5-session CPRT may be as effective, as shorter intervention may have a higher potential to retain parents in the intervention and thus have an increasing chance of assisting the parents in attaining proficiency in handling their child's behaviour problems.

Parent 2's comments in Study 1 suggested that the therapist's demonstration of a child-centred play session might have promoted a high level of engagement in the CPRT for them. For example, Parents 2 reported that they were reassured about the usefulness of the child-centred play session for their child after the demonstration. They also reported increased interest and confidence in the 10-session CPRT model. The benefit of having the opportunity to observe the therapist demonstrating the play therapy strategies with her child was reported by a mother as "the best way to learn it" in a qualitative study of FT (Foley, Higdon, & White, 2006, p. 48). The parents' expressions suggested that the demonstration of play sessions with the targeted child could be important in promoting and maintaining parents' engagement, thus enhancing intervention gains.

Based on this discussion for the next study, three components have been identified as potentially important, specifically in promoting a quicker rate of improvement in a therapeutic approach. These pertain to the duration of the intervention, the contents and the procedures, (a) the duration of the intervention is to be reduced by half, (b) the contents of the first five sessions of CPRT are considered to be more influential than the others for intervention outcomes, and (c) the addition of a live demonstration of the child-centred play session with the targeted child by the intervention provider in the participant's home, is regarded as an important procedure to promote parents' engagement as well as to enhance intervention gains. These three specific components of CPRT are, from Study 1, fundamental to promoting early and substantial intervention outcomes.

Implications from the Within-Intervention Analysis

The analysis facilitated a better understanding of the relationship between specific strategies and the particular child behaviour across interventions. However, owing to the limited number of participants in each experimental condition, the findings are considered as exploratory rather than having external validity. The findings in Study 1 indicated that most

of the children's behavioural problems as nominated by the parents reduced following the early sessions of CPRT and STP, when *reflective responses,* the *be-with attitude,* the *A-C-T limit-setting* and its rationale, the *1-2-3 time out* and *clear instructions* were taught. Particular behavioural problems of the individual child reduced following some strategies taught in CPRT and STP, which include *encouragement, esteem-building, choice-giving as consequences, quality time* and *descriptive praise.* Further discussion of the analysis is detailed as follows.

Reflective responses and the *be-with attitude* (executed using behavioural descriptions, undivided attention, etc) taught in the first CPRTsession were followed by considerable improvement in most of the two children's nominated behavioural problems. They both reduced their temper-tantrums, hitting incidents and non-compliance. These results were consistent with those of a study of FT (Topham et al., 2011), which indicated that the parent's undivided attention, unconditional acceptance and *reflective responses* may initiate emotional and behavioural regulation in his or her child. These findings were also similar to those of a FT case study which reported a successful experience of a grandfather using these strategies to manage the tantrums of his grandson effectively (Boyer, 2011). Moreover, a mother of a six-year-old boy with behavioural problems reported that the basic play therapy skills taught in the first three sessions of CPRT, including *reflective responses* and the *be-with attitude*, enabled her to conduct child-centred play sessions that made her child "feel like he was special" and led to an increased openness between them (Solis, Meyers, & Varjas, 2004, p. 106). In a previous study of FT, two parents indicated that *reflective responses* were appreciated by their children and thus supported the children to work on their own emotions, and at the same time it helped the parents to calm down while communicating with their children (Foley et al., 2006). The results of Study 1, and other studies cited above, exemplify

the importance of the *be-with attitude* and *reflective responses* as the key components of CPRT.

The *A-C-T limit setting* and *1-2-3 time out* were useful in managing inappropriate and challenging behaviours. The results of the within-intervention analysis showed that the *A-C-T limit-setting* strategy taught in the fourth CPRT session was followed by reductions in temper-tantrums, incidents of hitting and non-compliance in both children. These findings are similar to those of a FT case study which reported that a grandfather witnessed how the *A-C-T limit-setting* strategy helped his grandson to identify and manage his anger (Boyer, 2011). Moreover, in Winek and colleagues' study (2003), parents' use of *A-C-T limit setting* had been identified as a facilitative factor for positive child outcomes. The *1-2-3 time-out* taught in the third STP was followed by a considerable reduction in the number of hitting and defiance incidents of Child 3.

Despite the conceptual variation between *A-C-T limit setting* and *1-2-3 time-out*, they both assist the parent to utilise three simple steps to reduce problematic behaviour in the child. The positive outcome on child behavioural problems after both strategies were taught to the parents might have been due to their similarity in the implementation of a step-by-step strategy. Taken together, the above findings justify the need to teach the *A-C-T limit setting* to parents as a key component of CPRT in managing the destructive behaviour of their children.

The rationale for using *reflective responses* and the *A-C-T limit setting*, which were presented through *precise messages* and the implications of different messages, taught in the fifth CPRT session were followed by a substantial reduction in all nominated behavioural problems of both CPRT children; most of the child behavioural problems were recorded at their lowest levels after that session. The findings suggested that the understanding of the rationale of a strategy might have increased the parents' acceptance of the strategy, which

ultimately helped them in mastering and implementing the strategy. These findings are similar to those found in Eyberg and Matarazzo's (1980) study which indicated improvements in the mother's facilitative behaviour, including *descriptive statements*, and child behaviour, comprising noncompliance and inappropriate behaviour, after the mother attended five 20-minute training sessions of the individual PCIT. *Clear instructions* taught in the third STP session were followed by reductions in defiance and hitting incidents. This strategy has a similar objective to *precise messages* as both are designed to replace harsh commands typically used by the parent in reaction to the child's problematic behaviour. The results of Study 1 demonstrated the importance of to enhance parents' understanding of the rationale of *reflective responses* and *A-C-T limit-setting* by teaching them to use *precise messages* and to understand the implication of different messages, as a key component of CPRT to increase parents' awareness of their own verbal contents while communicating with their children.

Other strategies taught in CPRT and STP in Study 1 were followed by positive changes in particular behavioural problems. For example the *choice-giving strategies*, including *positive choices* and *choice-giving as consequences*, *esteem-building* and *encouragement* strategies taught in CPRT were followed by a reduction in interruptions and switching off behaviours but not in non-compliance. A closer inspection showed that Child 1 who had positive response in terms of behaviour after these strategies were taught to the parent had a negative self-concept as indicated on his JPSCS score at baseline, as shown in Table 9. This suggested that the above strategies may have been more effective in managing a passive form of acting out behaviour driven by low-self-esteem than oppositional behaviour. These findings are supported by a parent's self-report in a previous study of FT that highlighted the importance of *encouragement* in helping her 4-year-old daughter to develop self-esteem, thus behaving positively (Edwards, Ladner, & White, 2007). In regard to the findings in Study 1,

choice-giving, *esteem-building* and *encouragement* strategies could be an effective strategy in managing problem behaviour in children with behavioural problems who also have low levels of self-esteem.

After *positive parenting* strategies were taught in the STP, including *quality time* and *descriptive praise*, different changes in child behaviour were followed. For example, a reduction in defiance but an increase in hitting incidents in Child 3 was recorded, after the positive parenting strategies were taught to his mother. For Child 4, an increase in all nominated behavioural problems, including non-compliance, temper-tantrums and hitting incidents, was followed after the same strategies were taught to Parent 4. These findings were similar to those of a single-case exploratory study of PCIT, for instance the child's negative behaviour reduced at post-intervention, but increased at follow-up, even though the number of *descriptive praises* given by the mother increased (Borrego & Urquiza, 1999). It is worth noting that the objective of the positive parenting strategies was to promote positive behaviour in children rather than to diminish negative behaviour. Therefore, the possible relationship between the strategies and the child's positive behaviour was undefined as the parents were not required to record the child's positive behaviour in Study 1.

If an intervention could be tailored to individual families, child characteristics could be an important criterion for deciding what strategies could be more effective. Studies suggested that child characteristics are an important factor contributing to the development of behavioural problems (Egger & Angold, 2006; Hughes & Ensor, 2009; Miller-Lewis et al., 2006). The baseline data of Study 1 showed that the children were different in the levels of self-concept and the intensity of their behavioural problems. In addition, each child was recorded as behaving differently after some strategies were taught to their parents, such as *esteem-building* taught in CPRT and *descriptive praise* in STP. In regard to these findings, it

might be helpful if the adapted CPRT could have the flexibility to be tailored to a child's specific behavioural problems as well as the child's characteristics, such as self-esteem.

Other possible explanations of the child's behavioural changes in a different direction after the same strategies were taught to the parents are (a) a different quality of implementation of the strategies by the parents, and (b) different levels of parental acceptance toward a specific strategy, if not the direct effect of a strategy (Edwards et al., 2007; Solis et al., 2004). If these are the cases, then the parent's perception and acceptability of the intervention contents and their rationales would need to be taken into account when helping the parent implement and master a specific strategy. The lack of empirical support in the existing literature, as well as in Study 1, for any of the possibilities stated above warrants the need for exploring and clarifying these hypotheses through research. Therefore, when including all of these proposed elements in a parental intervention as discussed, its practicality, in terms of its outcomes, need to be tested in further studies.

There was a challenge in evaluating the findings of Study 1 as few studies, which investigate the outcomes of two or more parent interventions using single-subject designs, are available for comparison. An abundance of controlled-outcome studies was found to support the efficacy of different parenting interventions quantitatively; however single-subject studies and qualitative research which aim to investigate how an intervention works are still limited. To date, only a few studies have been found to investigate the process of change in a parenting intervention, such as FT (e.g., Winek et al., 2003). In addition, specific outcomes of particular contents and procedures of an intervention were not reported in most of those studies (Kazdin, 2000). They, basically, failed to capture or report the entire intervention process in greater depth and when and how the changes occurred.

The within-intervention analysis of Study 1 indicated positive changes in the children's behaviour after five CPRT strategies were taught in the first 5-session of the 10-session

CPRT. The "four" strategies, *reflective responses*, the *be-with attitude* (behavioural descriptions), *A-C-T limit-setting*, *precise messages* and the implications of different messages (embedded in the rationale of A-C-T limit-setting and reflective responses), are proposed to be included in the 5-session adapted CPRT. They are grounded in client-centred theory, which provides a perspective on the relative success of these strategies as compared to the STP and other common approaches used in some parent-training programmes, which draw from social learning theory.

Theoretical Foundations of the Four Strategies

To facilitate constructive changes, the tenet of the problematic area is first to be understood from the perspective of the theory grounded in an intervention (Urquiza, 2010). In the case of CPRT, the person-centred theory was referred to and destructive behaviour is operationalised as a manifestation of the distortion or rejection of the experience that is incongruent with one's self (Rogers, 1939, 1951). Based on this conceptualised understanding of child behaviour problems, the rationale of using the 'four' strategies and how each of them works to facilitate positive changes in child behaviour were discussed as follows.

Reflective responses and the *be-with attitude* were initially the apparatus of person-centred therapists and were later adopted by play therapists, including Virginia Axline (1947, 1969), to establish a therapeutic relationship with the clients, in this case children, for constructive changes. Rogers and Dymond (1954) emphasised that, "the child will become more socialized and mature in his or her behaviour, more self-responsible and more co-operative" as a sign of moving towards his or her tendency of growth, in the therapeutic relationship, when the child perceives himself or herself as being heard, understood, cared about and accepted (p. 5). For these reasons, *reflective responses* and the *be-with attitude* (through the use of behavioural descriptions, acceptance, etc.) are taught in CPRT, as these

strategies help the parent to develop the therapeutic relationship with the child through conveying his or her understanding, acknowledgement and acceptance of the child's intention beneath the behaviour to the child, which would lead to increased self-awareness (Rogers, Gendlin, Keiesler, & Truax, 1967). According to person-centred theory, *reflective responses* and the *be-with attitude* are imperative to initiate the therapeutic parent-child relationship necessary to promote self-initiated positive changes in the child. The theory provides an explanation for the decreasing trend in behavioural problems in the CPRT children after these approaches were taught to their parents.

Unlike social-learning-based strategies which are focused on direct alteration of parenting behaviour (Scott & Dadds, 2009), *reflective responses* and the *be-with attitude* are based upon fundamental changes in parents' attitudes and responses, and thus creating the therapeutic condition between the parent and child to initiate positive and self-directed change in the child. The therapeutic relationship is a common element in most, if not all, psychological interventions, but it differs in the way its function is to be defined, which in turn determines the strategies used to achieve it. For example, *quality time* and *positive attention* taught in STP are aimed at increasing warmth between parent and child and providing rewards for positive behaviour respectively (Sanders et. al., 2003). By focusing on the external contingencies in a child's behaviour, these strategies are designed to promote positive behaviour first, in order to implement punishing strategies later to weaken negative behaviour, as in most of the social-learning-based intervention (Scott & Dadds, 2009). Based on the conceptual underpinning of these strategies, *reflective responses* and the *be-with attitude*, as well as the therapeutic relationship, are fundamental for CPRT, while *quality time* and *positive attention* are secondary to reinforcement strategies in STP.

The *A-C-T limit-setting* helps the parent to provide the child with an active support for alternative behaviours or expressions to replace the unacceptable behaviour of the child, such

as aggression. It involves three simple steps. First, the parent acknowledges the child's emotion or need to promote emotional regulation by saying "I know you are angry with me". The limit on the child's behaviour is then communicated as a matter of fact without assaulting the child, for example "…but I'm not for hitting". Lastly, the parent targets one or two alternatives as guidance for behavioural regulation by saying "You can hit the pillow and pretend that's me". For the parent, *A-C-T limit-setting* facilitates them to distinguish between the child's intrinsic need and extrinsic behaviour, and thus respond to them accordingly. For the child, it allows him or her to express one's need or emotion in a socially accepted manner. It delivers a clear message to the child that one's inner-self is valuable and acceptable but not one's destructive behaviour. The underlying principle of the *A-C-T limit-setting* provides an explanation for the decreasing trend in behavioural problems in the CPRT children after it was taught to the parents.

The *A-C-T limit-setting* assists the parent to provide limits and alternatives as guidance for the child's destructive behaviour instead of a disciplinary practice as is used in the *1-2-3 time-out* taught in STP. Both of these strategies are designed to weaken a child's negative behaviour but are grounded in two contrasted diagnostic understandings of child behavioural problems; the former believes that the child's behaviour is driven by their internal forces while the latter focuses on altering the external contingencies that are considered as the decisive factor for child behavioural problems. The *A-C-T limit-setting*, used in CPRT, aims to foster a series of changes in a child, which is indicated in person-centred therapy (Rogers, 1951). First, the child comes to understand his or her deeper emotion or need beneath the behaviour through the parent's reflection. Then, a sense of self-acceptance flourishes in the child through the parent's acknowledgement and acceptance of the child's need or intention. Consequently, the child's self-congruity is increased, as he or she no longer needs to deny or distort his or her experience. Ultimately, a sign of a tendency towards positivity is witnessed

in the child, when he or she accepts the alternative expression, which is socially accepted, as suggested by the parent. The *A-C-T limit-setting* encourages the parent to value the child's aptitude for positivity in the therapeutic parent-child relationship, rather than provide an immediate punishing experience, such as used in the *1-2-3 time-out* strategy, when the child misbehaves.

The parent's awareness of the rationale of *reflective* responses and *A-C-T limit setting* could be enhanced by emphasising the use of *precise messages* and the implications of typical parental messages. This might encourage the parent to use specific statements and verbal responses when interacting with the child. *Precise messages* incorporate the use of reflective responses that emphasise the need to identify and acknowledge the intentions of the child's behaviour. Therefore, introducing these strategies ensures that the parent's emphatic understanding of the child's needs and emotions, and the parent's motive to disengage the child from destructive behaviour are precisely delivered through the parent's message. These strategies increase the likelihood that the parent's message will be accurately perceived by the child. Rogers (1951) indicated that a child's inherent strength would be "most facilitated" when the parent was able to convey his or her "empathic understanding to the child" (Rogers & Dymond, 1954, p. 4). Rogers' theory clarified how the parent uses *precise messages* and the implication of different messages to help the child regulate his or her emotions. For instance, a substantial improvement in all nominated behaviours of the CPRT children followed after these approaches were taught to the parents in Study 1.

Analytical Discussion of the Process and Procedure for the Adapted CPRT

Studies have suggested that parents' perceptions of the meaning of their child's behavioural problems, known as parental attributions, are likely to influence the way the parents respond to their children (Fite, Colder, Lochman, & Wells, 2006; Hastings & Rubin, 1999; Johnston & Ohan, 2005; Snyder, Cramer, Afrank, & Patterson, 2005). For example,

some parents believe that child behavioural problems are intentional (Baden & Howe, 1992; Hastings & Rubin, 1999), while others perceive them as a revenge response a child uses against them (Scott & Dadds, 2009). Others may believe that it is a sign of being unloved by or unconnected to their child, as stated by Parent 2 in Study 1. Studies found that mothers who percieved their children's destructive behaviour as intentional would have a greater emotional reaction towards their children, and thus have a greater tendency to use the force of authority, including punishment and harsh discliplince, when their children misbehaved (Hastings & Rubin, 1999; Morrissey-Kane & Prinz, 1999). Some might attempt to withdraw from their children when the children escalated their aggressiveness (Baden & Howe, 1992). On the other hand, parents who perceive themselves as being unloved by or unconnected to their child, might be disposed to disengage with the child whenever possible, which is likely to cause the parent-child relationship to deteriorate (Morrissey-Kane & Prinz, 1999). These studies, in fact, provide some examples of how negative and problematic parental perceptions of child behavioural problems could elicit a series of emotional and behavioural reactions, which are destructive and bidirectional, in the parent and child with a subsequently negative impact on the parent-child relationship.

Regardless of the types, parental perceptions of child behavioural problems strongly influence the parents' help-seeking tendency as well as their subsequent engagement in an intervention (Mah & Johnston, 2008; Morrissey-Kane & Prinz, 1999; Snyder et al., 2005). For example, a parent who believes his or her child is taking revenge may feel that an intervention, which does not address a child's 'revenge' against the parent, is suitable for neither the parent nor the child. Another parental belief is that 'my child doesn't love me', and so my child isn't like other children who love their parents, therefore, this intervention is not going to be effective for my child. Morrissey-Kane and Prinz (1999) stressed that parental perception of an intervention as important and relevant to them may affect their

motivation and sense of urgency to participate and their levels of participation engagement, which is critical to intervention success. Parents who develop either of these attributions take no responsibility for the development of their children's behavioural problems, believing that it should not be they who are the targets of an intervention for child behavioural problems but their children. Even if they have started an intervention, they would be more likely to drop out or limit their participation. Given that parent participation in and engagement throughout an intervention are both critical to intervention effects, the above negative parental attributions, which discourage parental participation and engagement, are likely to jeopardise the ultimate intervention outcome, and thus need to be addressed.

The need to address negative parental attribution is undeniable. However, discovering what can and how to initiate change in negative parental perceptions is critical, as they greatly influence parents' acceptability of an intervention, the key to intervention success. By referring to client-centred theory, change in a parent's negative perception of the cause of his or her child's behavioural problems would not be lasting if the parent did not initiate change in his or her attitude and response towards the child, which is critical to treatment success (Morrissey-Kane & Prinz, 1999). As indicated in client-centred theory, the parent is more likely to explore, comprehend and thus accept his or her child's inner worlds, if the parent is trying to understand the cause of the child's behavioural problems, thus initiating a constructive change in negative parental attribution. Based on this assumption, Rogers' (1939, 1942) conceptual understanding of child behaviour problems is to be introduced to the parent in the early sessions.

The parent would be helped to understand why problematic or negative behaviour of a child is regarded as a symptom of incongruities in the child's inner world (Rogers, 1939; Rogers et al., 1967). Then the parent would realise that behavioural problems take place when a child denies or distorts his or her experience, which is unparalleled to the child's

awareness or concept of self, in order to protect one's self-worth (Rogers, 1939, 1979). For example, a boy who values himself highly is upset when he feels devalued by his mother. He views the experience of devaluing as insulting and unparalleled to his concept of self and thus he denies the experience. To do so, he rejects his feeling of unhappiness and replaces it with a resentful feeling and expresses it by hitting his mother. Specific examples concerning the particular parent-child dyad would be used to illustrate the incongruity between one's experience and self-perception to the parent to help the parent distinguish between the child's intention and expression, which is often exhibited in a form of destructive conduct. Thus they would be able to respond to each the child's intenon and expression accordingly with the support of some specific strategies which will be taught later.

Knowing how to address negative parental beliefs might have a positive impact on parent and child outcomes. While interventions are mainly focused on "what is generally effective for parents", Baden and Howe (1992) suggested that parents who seek help for child behaviour problems are generally more concerned about "how effective I can be with this particular child" (p.470). This, in fact, points to the need to redirect the focus on parental discipline practices to affective responses to address problematic parental beliefs. Scott and Dadds (2009) acknowledged the necessity of addressing parental belief which is likely to jeopardise intervention outcomes; however existing social-learning-based intervention, such as STP, does not indicate how to do this. Havighurst and colleagues (2010) questioned the impact of social-learning-based parent intervention, such as STP, on a child's emotional and behavioural competency as it does not address the parent's emotional responsivity to the child but parental practices (Snyder et al., 2005).

Changing parental beliefs is difficult, but not impossible. Rogers (1939), Scott and Dadds (2009) admitted the challenge in changing parental beliefs, but at the same time specified the potential means of achieving it. According to Rogers (1967), the ability to

change parental misbelief largely lies in the therapists' ability to accurately perceive the inner experience, or perhaps the perception, of the parent. This ability would flourish when the three characteristics of person-centred therapists, namely genuineness, unconditional positive regard and emphatic understanding, are continuously presented together, at least to some degree. This quality or ability of a therapist is especially needed when the philosophical conceptualisation of child behaviour problems grounded in an intervention vary widely from the parent's existing perception of the child and the cause of the child's behaviour problems. Scott and Dadds (2009) indicated that parents who have negative beliefs about child behaviour problems cannot put the strategies they know they should use in place and thus do not respond to intervention. They suggested that additional therapeutic methods could be used alongside social-learning-based parent training to help the parents repossess a sense of control by redefining their child's problematic behaviour and understanding of the parent's need and perception fully.

The role of the three characteristics of person-centred therapists in addressing parental beliefs has to be fully understood by a therapist for optimum therapeutic outcome with a family. These characteristics of the therapist can be expressed through his or her attitude, as well as verbal and non-verbal behaviours, when interacting with the parent and child. By expressing these characteristics, the therapist creates an opportunity to identify, communicate and value different belief systems with the parent in a respectful and collaborative manner. The three characteristics, when presented together to some degree, create a safe and non-judgmental space for the parent to freely ventilate his or her thoughts, feelings and concerns regarding the child and self as a parent. This quality relationship between therapist and parent is essential in promoting the parent's initial engagement. Moreover, this positive parent-therapist relationship could be strengthened during the course of the intervention and subsequently transformed into a therapeutic working alliance, which may eventually increase

the parent's involvement in the intervention process. Genuine, unconditional positive regard and empathic understanding, when presented together to some degree by a therapist, could establish a therapeutic relationship between therapist and parent for constructive change in the parental belief system, which may potentially increase the intervention outcome.

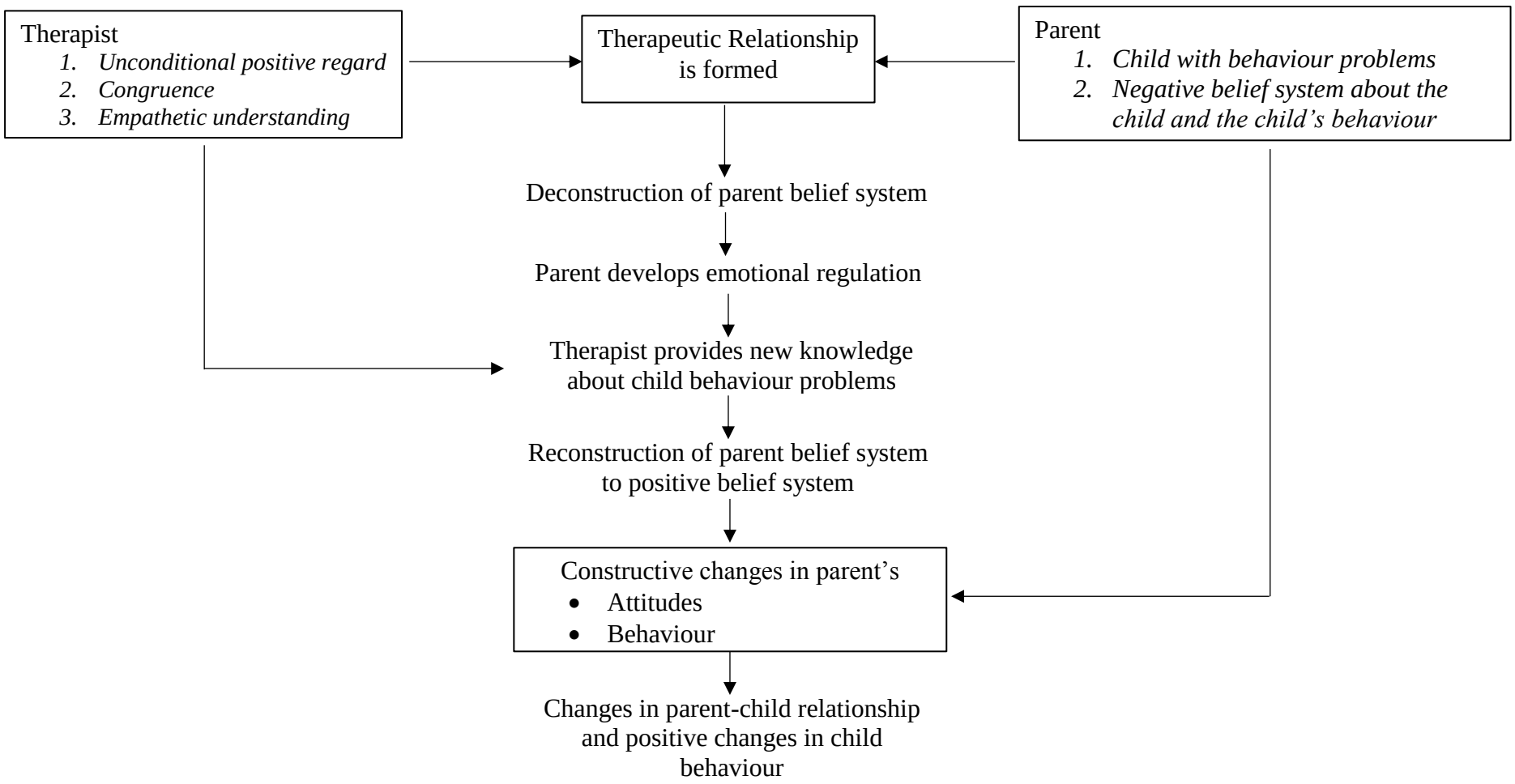


Figure 31. The process deconstruction-reconstruction: An analytical process between the therapeutic relationship between the therapist and parent and constructive changes in the parent

Figure 31 (p.158) illustrates an analytical relationship between the formation of a therapeutic relationship between the therapist and parent and constructive changes in parent beliefs, attitudes, and behaviour. A helping relationship, according to the person-centred theory, consists of a therapist who is in a congruent psychological state and a client who is incongruent. In this case, a parent is regarded as a client, who is incongruent with a negative belief system or misperception of his or her child and the cause of his or her child's behaviour problems, and engages in a therapeutic relationship with a therapist who is congruent in the relationship by maintaining the three fundamental attitudes, namely genuineness, unconditional positive regard and empathic understanding (Rogers, 1979). The parent feels safe and accepted within the therapeutic relationship, thus disclosing his or her feelings and thoughts freely as a sign of engaging in the process of self-regulation.

Consequently, the parent is more likely to deconstruct his or her perceptions about the child and the cause of the child's behaviour problems, of which they were once defensively unaware. Rogers (1967) suggested that when such an incongruity is brought into consciousness, a constructive change in the belief system is imposed. It offers a window of opportunities for the parent to reconstruct the problematic belief system or misperception into a positive form. Therefore the new knowledge of child behaviour problems is best introduced at this point. The new positive parental belief system regarding the child and the child's problematic behaviour would then bring about constructive changes in the parent's attitudes and behaviour toward the child. This analytical assumption is supported by Winek and colleagues' (2003) findings which suggested that parents who achieved self-awareness as a result of FT are motivated and their behaviours towards their children are positively adjusted.

In the process of deconstruction-reconstruction of parental misperceptions of the child, it specifies the role of the three characteristics of person-centred therapists in establishing a therapeutic relationship between the therapist and parent, which allows the parent to address

and untangle the negative belief system of the child and the cause of their child's behavioural problems. If a therapeutic condition for growth is provided by the therapist to the parent, it would help the parent to deconstruct the incongruent perception of the child, which is more likely to bring about constructive progress in the intervention. When the parent's misbeliefs have been deconstructed, the parent would be less resistant to exploring the phenomenon of child behavioural problems with the therapist. The parent is more prepared to build a new knowledge of self and the child. At that stage, the parent is characterised as self-governing and is motivated to unlearn the previous parenting style and explore new parenting approaches. The parent will take an active role in reconstructing the misperceptions of the child and the cause of the child's behaviour problems and with this initiates an attempt to assist and reconnect with the child. As a result, the parent is more likely to increase his or her acceptance of and affection for the child. These analytical assumptions suggest that the parent's understanding of the proposed phenomenon of behavioural problems may increase his or her willingness to consider a new way to counter one's concerns and at the same time open up a window between the parent and child to re-establish and strengthen their bond.

These analytical statements also suggest that a parent's existing knowledge of self and the child, which presents prior to a therapy, and which is negative, can and has to be deconstructed during the therapy in order to reconstruct it into a new and constructive form of knowing. The three afore-mentioned characteristics of the therapist are the prerequisite means to address incongruities in parental beliefs. Rogers' conceptualisation of child behavioural problems, then, can be introduced to the parent as a new way to comprehend the child and the child's behaviour, as it helps the parent to reconstruct the negative beliefs about the child. The three characteristics of the therapist and the conceptualisation of child behavioural problems are equally important in the process of deconstruction and reconstruction of parental beliefs.

No matter how valuable a new knowledge is, if it is beyond comprehension it is impractical. Therefore, to increase the parents' understanding of, and acceptance of self and the child, Rogers' conceptualisation of child behaviour problems needs to be introduced using a simple and precise manner and example; in such a way, a therapeutic parent-child relationship is more likely to flourish earlier and the child's problematic behaviour is more likely to be reduced sooner. As discussed, if a lengthy time period is required before the child's problematic behaviour is reduced, parent retention in the programme may be affected. Therefore, techniques which can induce the parent to examine and change parenting beliefs must be sufficiently powerful to be effective very early in the therapeutic process. The incongruities between self and experience are somehow abstract for the parent. Therefore, the explanation would be the occurrence of child behavioural problems, in the adapted CPRT model, as being a manifestation of the child's negative emotion and intention, rather than a symptom of incongruities as suggested by Rogers and Dymond (1954).

Adding to Rogers' (1942, 1951) theory, a possible way to explain child problem behaviour to the parent is to suggest that destructive conduct is an ineffective form of help-seeking behaviour that a child uses to communicate his or her need for constructiveness. These additional notions of child behaviour are aligned with Rogers' concept of the incongruities between self and experience as the source of externalising problems. These views of child behaviour are also in line with the attachment theory which indicates that a child is likely to behave maladaptively towards others if he or she does not have a "trustable and secure figure" to respond to his or her emotional needs (Scott & Dadds, 2009, p. 1443). Therefore, within this proposed model, strategies to establish a therapeutic relationship between therapist and parents and between parent and child can continue to be identified as the means for constructiveness and treatment success. These suggested notions of the occurrence of behavioural problems are an abridgement of Rogers' conceptualisation of child

behavioural problems to enhance the parents' comprehension and intervention outcome. The notions, if included, are likely to enhance the value of the adapted CPRT model.

CPRT is an experiential therapy. The parents who engage in a therapeutic relationship with the therapist are more likely to establish this relationship with others – in particular, their child. By practising the "five" strategies or approaches in adapted CPRT when interacting with the parents, the therapist provides an opportunity for the parents to experience and deeply understand how these approaches impact on self-constructiveness and hence be certain of their effectiveness. As a result, the parents will have an increased ability to learn and implement the strategies and approaches. This experience intensifies the parents' intention to replicate the approaches when interacting with their child. Similarly, the child who experiences acceptance from the parents will be less provoking and more cooperative. With respect and acceptance from the parents, the child is more likely to encounter their deepening incongruities in the process of self-discovery. This indicates that experiential learning is a means to initiate self-directed change in CPRT as well as in the adapted module.

In addition, the live demonstration of child-centred play sessions with the child of focus seemed to increase the parents' (Family 2) confidence in the usefulness of the approach and the competency of the therapist in the initial pilot study. It aims to increase parents' self-confidence and to strengthen the working alliance between therapist and parent. Its impact is, rather, beyond the concept of modelling in enhancing intervention outcomes. Therefore, a live demonstration of child-centred play sessions with the child of focus would be included as a procedure in the adapted CPRT.

Study 1 provided important information to support the revision of the 10-session CPRT model, in terms of its length, strategies and procedures, which were indicated as potentially changeable to reduce barriers in parents' engagement (Lundahl et al., 2006) and enhance intervention gains. The fundamental notion of the programme is to facilitate parents to

establish a therapeutic relationship with their child as outlined by Rogers and Dymond (1954) and in the CPRT manual (Bratton et al., 2006). A conceptual model was developed to illustrate the potential development of interaction between the parent's implementation of strategies, the child's behavioural improvement and the parent's retention in the therapy. The analysis supports a proposed adapted five-session CPRT. A live demonstration of child-centred play sessions with the child of focus would be incorporated in the programme to enhance parents' engagement and intervention gains.

A further investigation of the approaches of the 10-session CPRT identified four strategies or approaches, which include (a) *be-with attitude* (by teaching behavioural descriptions), (b) *reflective responses*, (c) *A-C-T limit-setting*, (d) *precise messages* and *implications of different messages*, to enhace parents understanding of the rationale of *A-C-T limit-setting* and *reflective responses*, may have been the key components for treatment success in Study 1. Other strategies were indicated as supplementary strategies for parents of children with specific types of behavioural problems. While retaining the characteristics of the CPRT as an experiential therapy, an analytical model of deconstruction-reconstruction which attempts to conceptualise the therapeutic process undertaken by the parent(s) and child in a holistic manner towards positive changes has been proposed within the structure of the adapted 5-session CPRT.

The Adapted Child-Parent Relationship Therapy Model

Drawing on client-centred theory (Rogers, 1951) and CPRT (Bratton et al., 2006), the researcher adapted the CPRT. The goal was to develop a shorter intervention for parents of young children with behavioural and emotional problems, which retained the fundamental goal of the original CPRT in developing a therapeutic parent-child relationship. To achieve the goal within a shorter timeframe, the adapated CPRT emphasises reconstructing the parent's misperceptions of what causes the child's behavioural problems. By achieving both

of the above goals, the parents would be able to help their children better regulate their behaviour and emotion. As a result, it was expected that the child's negative behaviour would be reduced more rapidly, which is consistent with parents' need for and expectation of an intervention.

The adapted CPRT was a 5-session, 60- to 80-minute weekly, individual family-oriented intervention, which incorporated child-centred play therapy. It maintained the basic strategies of CCPT taught in the original version of CPRT (Bratton et al., 2006). They are (a) *reflective responses* (b) *be-with attitude* (behavioural descriptions and the basic principles and strategies of child-centred play therapy), (c) *A-C-T limit setting*, (d) *precise messages* and the implication of typical parents' verbal responses and, (e) and two other responses, including *esteem-building, acknowledgement, positive-choices* and *choice-giving as consequences*, are selected and introduced for individual families as supplementary strategies in the adapted CPRT. Apart from that, two additional components were added in the adapted CPRT. They were (f) the cause of behavioural problems, which focuses on reconstructing parents' misperceptions; and (g) a list of possible behavioural and emotional clues for deeper emotions and thoughts of young children, which focuses on facilitating parents to help their children reduce negative behaviour.

Table 14

Contents of the adapted CPRT compared with the original CPRT

Session	Content	
	CPRT	Adapted CPRT
1	Clinic visit. Principles and objectives of CPRT. *Reflective responding* & *Be-with* attitude.	• Clinic visit. • Principles and objectives of CPRT. • Deconstruct-reconstruct parents' negative belief system regarding themselves, their children & child behavioural problems. • *Reflective responding* & *Be-with* attitude. • Video demonstration of *reflective responding.*
2	Clinic visit. Basic principles of child-directed play session and toys for play sessions • Video demonstration of the *Be-with* attitude through *behaviour tracking* & *reflective responding*.	• Clinic visit. • Basic principles of child-directed play session and toys for play sessions. • Play sessions Do's & Don'ts and play session procedures. • Video demonstration of the *Be-with* attitude through *behaviour tracking* & *reflective responding* and play sessions Do's & Don'ts and procedures.
3	Clinic visit. Play Sessions Do's & Don'ts and play session procedures • Video demonstration of the *Be-with* attitude, letting the child lead, *reflective* responses and basic limit setting.	• Home visit. • A live demonstration of play sessions. • *A-C-T limit-setting* method. • The rationale of the 3-step *A-C-T limit setting method.* • Precise messages & implications of typical parent responses to unacceptable behavior.
4	Clinic visit. *A-C-T limit setting* method • A-acknowledge the child's feelings • C-communicate the limit • T-target acceptable alternatives	• Home visit/ clinic visit. • Supervised parent-child play session. • Understand and manage unaddressed emotions and undesirable behavior of the child. • Application of up to two specific strategies, such as *encouragement, esteem-building* and *choice-giving* methods, depending on the type of behaviour displayed by the child and the parent and child's characteristics.

Session	Content	
	CPRT	Adapted CPRT
5	Clinic visit. The rationale of the 3-step *A-C-T limit setting* method. • Precise messages & implication of typical parent responses to unacceptable behavior.	• Clinic visit. • The parent evaluation of family's progress. • Planned strategies to maintain positive changes and challenging situations.
6	Clinic visit. *Choice-Giving* Methods • Demonstrate how to avoid potential problem behaviour by presenting children with opportunities for decision-making, problem-solving, and self-control.	
7	Clinic visit. *Esteem Building* Responses • Discuss positive character qualities. • Demonstrate how to develop a sense of competence in children.	
8	Clinic visit. *Encouragement* vs. *Praise* • Demonstrate how to encourage the effort rather than to praise the product.	
9	Clinic visit. *Choice-giving as consequences* for non-compliance behaviours. • Generalizing limit setting outside the play session.	
10	Clinic visit. The parent evaluation of family's progress. • Planned strategies to maintain positive changes and challenging situations. *Structured doll play*. • Teach the parent a lively way of storytelling to help their children who are feeling anxious or insecure.	• Booster session. (clinic visit/home visit) • Parent reports on the child's behaviour on ECBI. • Review the intervention principles and parent's goals. • Review & tailor strategies to address the current issues between the parent-child dyad. • A plan was made to achieve the parent's goals with selected strategies.

Session 1. The first session focused on establishing a therapeutic parent-therapist relationship through understanding the parent's perceptions of oneself as a parent, of the child and of what causes the child's behaviour problems. It began with building a therapeutic relationship with the parent by providing an opportunity for the parent to express and regulate his or her emotions on parenting and towards the child before helping the parent to understand the causes of child behavioural issues. Then, the key principles of the intervention, which emphasise maximising the individual strengths of the parent and child and establishing the therapeutic parent-child relationship in addressing child behaviour problems, were introduced. Later, the function of child behaviour as communication and intentions behind child behaviour problems were discussed by referring to the specific parent-child scenarios of the parent-child dyad, as introduced by the parent to help reconstruct the misperceptions. Following that, *reflective response* and the *be-with attitude* were introduced as strategies to help develop the therapeutic parent-child relationship and thus reduce child behaviour problems. This was introduced through discussion of some examples of parent-child interaction scenarios and worksheets that focus on the child's particular behaviours and emotions. At the end of the session, the parent's concerns were discussed before the parent was asked to practise the taught strategies at home whenever possible and to take notes when they did as part of the homework assignment, which would be reviewed in the beginning of the following session.

Session 2. This session was begun by reviewing the homework assignment from the previous week. Following that, the CCPT, including its goals, its basic principles, the suitable toys and materials and its procedures, were introduced. Then, the differences between the child-centred approach and an overly-permissive parenting approach in dealing with child behaviour problems were discussed along with examples. To equip the parent for conducting child-centred play sessions at home, the *be-with attitude* was emphasised by

teaching them to use *behavioural descriptions*, while *reflective response* was reviewed through live demonstration using toys and video-clips. In addition, the parent was taught to replace questions with statements and stop giving commands during child-centred play sessions. The rationales and implications of the taught strategies, as the basic skills used by a child-centred play therapist, were discussed using descriptive examples of parent-child interactions and video-clips of child-centred play sessions and demonstration using toys. A set of toys was provided for the parent to begin the weekly child-centred play session with the child at home and the parent was asked to put these items in a special place, not available for daily play, during the course of the study. At the end of the session, the parent's concerns were discussed. This was followed by assigning homework, where the parent was asked to conduct child-centred play sessions with their child at home, using the set of toys and the new strategies taught in Sessions 1 and 2, for 30 minutes once during the week and report the session on a recording sheet.

Session 3. This session was carried out at the family's home. First, the homework assignment was reviewed. Afterwards, a live demonstration of a client-centred play session with the focused child was provided. This was to enhance the parent's confidence in the intervention provider and to reassure her and him regarding the practicality of the approach and strategies with the child. This was followed by a discussion. Then, *A-C-T limit-setting* for undesirable behaviour and its rationale were introduced. This included a review of a list of typical parent responses to a child's unacceptable behaviour and negative emotions, and the implications of each. In addition, the functions and implications of communicating the limit (C) (in *A-C-T limit-setting*), as precise messages, were stressed by contrasting it with some other typical responses of parents to unacceptable child behaviour. Following that, practice worksheets were used to help the parent to master the taught strategy inside and outside of the child-centred play sessions. The parent was also asked to list down the

situations in which he or she needs to practise the strategy with the child and then the *A-C-T limit-setting* was tailored accordingly for the parent-child dyad through brainstorming and role-play with the parent. The parent's concerns were discussed before the homework was assigned. The parent was asked to continue a weekly child-centred play session with the child as well as to practise the *A-C-T limit-setting* inside and outside of the child-centred play sessions and to report those occasions in the coming session.

Session 4. The session was was carried out at the family's home. It started by reviewing the homework. Then, the parent was taught to understand and facilitate the child's unaddressed emotions by using the child's behaviours as the clues for the child's hidden emotions and unspoken thoughts. Following that, two specific strategies to address particular behaviour or characteristics of the child, were selected and taught to the parent. For example, *esteem-building* and *encouragement* were taught to the parent of the child who had low levels of self-concept or who exhibited a passive form of behavioural problems prior to the intervention, while *positive choices* was introduced to address temper-tantrums and noncomplaince and *choice-giving as consequences* was taught to manage aggression. Next, the parent's concerns were discussed. At the end of the session, the parent was asked to practise the taught strategies in addition to the weekly 30-minute child-centred play session and report them in the coming session.

Session 5. This was the final intervention session, no new strategies or principles were taught. Consistent with the rest of the session, except the first session, homework was reviewed at the beginning of the session. Following that, the parent was asked to evaluate and report on his or her as well as the child's growth and changes in the intervention thus far. Then the parent was guided to structure the new way of being with the child into an organised and realistic plan, which included the goals and strategies to achieve it. Later, the goals and principles of the intervention were re-emphasised. All taught strategies were briefly

reviewed. Strategies which were identified by the parent as helpful and effective in managing the child behaviour problems would be further discussed or tailored, if needed.

Booster session. A booster session, between the fourth and sixth weeks following the programme, was offered, when needed. The ECBI was administered once again to monitor the changes in the child's behaviour. The parent was offered a booster session if the parent rated the child with a higher score in the *Intensity* scale than its post-intervention score, or if the parent identified the need to attend the session. In this session, the changes in and progress of the parent and the child were reviewed as well as the obstacles. Then the impact of the strategies implemented by the parent following the conclusion of the intervention on the child's behaviour and the child's responses toward them were carefully reviewed to identify possible issues in terms of implementation of each strategy. Following that, the parent's current perceptions of the child and the causes of the child's behaviour problems were explored and discussed along with the revision of the intervention goals and principles. Later, the parent's concerns regarding the child's behavioural and emotional challenges were addressed by reviewing and tailoring a specific strategy to suit a particular parent-child interaction or issue. It was very important to respect the parent's view of the practicality and usefulness of a particular strategy and reach a mutual agreement with the parent on that in helping the parent to re-learn and re-master the strategy. At the end of the session, the parent was asked to set goals for him or herself and the child, as well as the ways or strategies needed to achieve them.

Rationale

The adapted CPRT, although manualised, has a greater flexibility in its application by allowing a selection of intervention components in Session 4 to match the specific issues and characteristics of the individual child and parent. Part of the session content was determined on the basis of the child and the parent's pre-intervention measures. The selection process

involved a brief discussion with the parent to ensure that their view of the child and their needs were considered and acknowledged. This approach reflects the concept of person-centred therapy by involving and facilitating the parent in the process of decision making. This was aimed at promoting or improving the parent's engagement, commitment and compliance and thus enhancing the overall intervention outcome.

Research Objectives

The purpose of the present study was to evaluate the effects of the adapted CPRT across participants and to determine process effects within each participant. Across participants, the impact of the adapted model of CPRT on parent and child functioning was assessed within a multiple-baseline across participants design. Multiple-baseline measures were taken from parent diaries of positive and negative child behaviours. In addition, measures of the following variables were taken at baseline, at the post-intervention and at Follow-up 2: parent reports of (a) child behaviour problems and (b) parenting stress; child report of (c) self-concept; as well as direct observations of (d) child responses and (e) parent responses during child-led play sessions. The parents' experiences and perceptions of the programme were also explored to determine the social validity of the programme and to gain insight into its practicality.

In order to examine the process of change, the relationship between the programme curriculum and the changes in parent-responses in the video sessions were examined using a within-participant multiple-baseline across parent behaviours design. In addition, the changes in the children's play behaviours during the child-led play sessions over the intervention period were examined. Play behaviours and activities initiated and engaged in by the child during the observed child-led play sessions were coded to capture the adaptive changes of the child, in the context of play across experimental conditions, if any.

The present study also aimed to address, within the two designs, several limitations and issues in CPRT research as indicated in previous studies (e.g., Frick-Helms & Drewes, 2010; Phillips, 1985; Urquiza, 2010). First, the current study evaluated the impact of the adapted CPRT for a particular child population, the child with behaviour problems. Second, single-subject design was used to advance the rigour of CPRT research, by, in the multiple-baseline across participants design, using random assignment to staggered baseline length to control for change factors, and in the multiple-baseline within participants design by systematically measuring changes in variables at the time they were targeted by the treatment. In addition, standardised measures were used to improve the validity and reliability of the findings. Furthermore, behaviour diaries were used to record changes in child targeted behaviour, while direct observation was used to capture changes in parent and child responses, in addition to parent reports to inform of treatment gains objectively. To reduce the potential bias in the parents' reports, post-intervention assessment was conducted in the week following the termination session. Finally, there was a response to one of Phillips' (1985, 2010) critiques that the child's play, which retains the clues for changes, was not measured and reported in filial therapy studies. The child's play behaviours and activities during the observed child-led play sessions were coded to determine the adaptive change in the child participants and discussed alongside other outcome measures.

Research Questions

In response to the above objective, the following research questions were formed. They fall within two overarching themes and are firstly: How effective was the adapted programme across all the participants? (Questions 1-6); and secondly: How did the programme work within the participants? (Questions 7-10).

1) Does the adapted programme lead to an improvement in targeted positive child behaviour across participants?

2) Does the adapted programme lead to an improvement in targeted negative child behaviour across participants?
3) Does the adapted CPRT lead to an overall reduction in parent-reported child behaviour problems across the participants?
4) Does the adapted CPRT lead to an improvement in child self-concept across the participants?
5) Does the adapted CPRT lead to a reduction in parenting stress across the participants?
6) Does the adapted CPRT lead to an increase in the parent's use of the child-centred play strategies in the video-recorded parent child play sessions?
7) What is the relationship between any changes in the parent's use of the child-centred play strategies in the video-recorded parent child play session and the teaching of these strategies in the curriculum?
8) Are there corresponding changes in children's responses during the video-recorded parent child play sessions?
9) Are there adaptive changes in the children's play during the video-recorded parent child play sessions over the intervention period?
10) What are the parents' experiences and perceptions of the adapted CPRT?

Research Methods and Designs

Design. This study employed two single-case designs, one with multiple baselines across parent-child dyads and one with multiple-baselines within parent-child dyads. In order to ascertain the effectiveness of the study there was a multiple-baseline A-B-C design, where A represents baseline, B represents intervention or post intervention and C represents follow-ups. The parent in each family started the intervention after a varying length of baseline, which was randomly assigned to them. The process of change was measured using a natural multiple-baseline design within participants which was nested within the multiple-baseline

design across participants. In this case there were multiple-baselines within participants, across target measures where baseline length varied depending on elapsed time to intervention for each variable.

Single-case research design was considered as the most compatible research design for the present study for several reasons (Ray & Schottelkorb, 2010). First, it was a rigorous alternative to randomised controlled trials to demonstrate the effects of the adapted CPRT on the parent-child dyads (Frick-Helms & Drewes, 2010), as it is "a powerful and storied strategy for evaluating behaviour change in individual subjects in responses to applied intervention" (Morgan & Morgan, 2009, pp. 126-127). Second, it allowed the researcher to exercise ethical considerations in examining the intervention's effect without exploring a large number of families in the experiment (Blampied, 2001), given that the intervention was newly adapted. Third it avoided the need for a non-treatment or wait-list control group. Fourth, it could be the best way to demonstrate the experimental effects, as a withdrawal strategy (e.g. a reversal design) was unethical in the case of the present study, and it was also unrealistic to expect that there would not be any carry-over-effects after an intervention session (Morgan & Morgan, 2009). Fifth, it was a type of research approach that is competently used to establish evidence-based practices (American Psychological Association, 2005; Blampied, 2014; Horner et al., 2005; Ray & Schottelkorb, 2010).

Multiple-baseline design across participants. The impact of the intervention on specifically targeted positive and negative child behaviour was determined using a randomly allocated multiple-base line design across participants. This design was used to answer Research Questions 1: "Does the adapted programme lead to an improvement in targeted positive child behaviour across participants?" and Research Question 2: "Does the adapted programme lead to an improvement in targeted negative child behaviour across participants?" The nominated target behaviours were tracked across baseline (A), which served as its own

control to determine the effects during the intervention phase (B) and again at follow-ups 1 and 2 (C1 and C2).

In addition, overall child behaviour and functioning, as well as the parents' improvement, in terms of stress and taught strategies, were considered across participants. This addressed Research Question 3: "Does the adapted CPRT lead to an overall reduction in reported child behaviour problems across the participants?"; Research Question 4: "Does the adapted CPRT lead to an improvement in child self-concept across the participants?"; and Research Question 5: "Does the adapted CPRT lead to a reduction in parenting stress across the participants?"; by administrating three standardised outcome measures, which included the ECBI, the JPSCS and the *Parent-Child Dysfunctional Interaction subscale* of the PSI-SF across participants. The standardised outcome measures were administered at baseline (A), post-intervention (B) and again at follow-ups 1 and 2 (C1 and C2). To address Research Question 6: "Does the adapted CPRT lead to an increase in parent's use of the child-centred play strategies in the video-recorded parent child play sessions?", scatterplots were used to depict changes in observed directive and non-directive responses across participants.

Justification of the multiple-baseline design across participants. The design was chosen for the present study to demonstrate the intervention effects on children with behaviour problems and their parents. The randomly allocated baseline lengths controlled for extraneous effects while causal inferences could be achieved with successive replication of intervention effects across subjects (Blampied, 2014). It was potentially to limit the possible effects of some uncontrolled variables on any behavioural changes that took place during the intervention, even if the nominated behaviours of each child were not considerably stable during baseline (Morgan & Morgan, 2009).

Multiple-baseline design within participants. In order to study the process of change, the relationship between the programme curriculum and the changes in parent-behaviour in

the video sessions was described using a natural multiple-baseline within-participants design across parents' responses. The design was used to answer Research Questions 7: "What is the relationship between any changes in parent's use of the child-centred play strategies in the video-recorded parent child play session and the teaching of these strategies in the curriculum?" The data of the parents' responses observed during the child-led play sessions as per DPICS at baseline (A) served as its own control. The baseline data for each strategy or set of strategies varied between one and four data points depending on which session the strategy targeting those responses was taught within. Within the A-B-C design the intervention was examined to assess the impact of the specific strategy or set of strategies taught in each session. Specifically, these were *reflective statements* taught in Session 1 (B1); *commands*, *information questions* and *behaviour descriptions* taught in Session 2 (B2); *A-C-T limit setting* and its rationale taught in Session 3 (B3); and *choice-giving and esteem building* responses taught in Session 4 (B4). The intervention effects were determined once again at Follow-up 2 (C2). Adding to that, the corresponding changes in the child's responses during the video-recorded parent child play session were determined to answer Research Question 8: "Are there corresponding changes in children's responses during the video-recorded parent child play sessions?" Then, the child's adaptive change, in the context of play (Research Question 9), during the parent child play session over the course of the study was described. The parents' perceptions of the adapted CPRT were briefly summarised, while the parents' experiences are discussed further in the discussion chapter.

Justification of the multiple-baseline design within participants. A major advantage of this design is that it allows the simultaneous measurement of multiple behaviours with the power of the design coming in and demonstrating whether the change in parent behaviour comes when the corresponding strategies have been taught in the curriculum.

Participants

The participants were nine parents and their eight children who met the criteria for behavioural difficulties as indicated by the ECBI (Eyberg & Pincus, 1999) together with the remaining criteria at baseline. Parents were seven biological mothers, a biological father and a foster mother. Of these, a set of biological parents participated (Family 3). Half of the parents were married, three were single mothers, who were either separated or never married, while one was in a *de facto* relationship. Parents were aged between 24 and 47 years; the mean age was 37. Four parents had tertiary degrees, one had a college certificate and four had attended high school. All married parents were from a single-income household family, while all single parents were unemployed at baseline.

Five children were male and three were female. Six children were identified as European, two were Maori-European and one was Asian. The children were aged between 47 and 77 months during baseline; the mean age was 58.75 months. Of these, three attended primary schools and five attended kindergartens. All mothers were the primary caregivers of their children and self-identified as having difficulty in dealing with their children's behaviours. All mothers reported that their children started to show some forms of behaviour problems, such as temper-tantrums and aggression, at least six months prior to the recruitment.

Table 15

Summary of Participant Characteristics at Baseline

Child	Gender	Presenting problems as reported by parents at intake/pre-intervention meeting	ECBI score	Baseline Days for PBD
5	M	'angry episodes', including temper-tantrums and aggression at home and school	140	10
6	M	temper-tantrums and clinginess at home and …at kindergarten	146	14
7	F	noncompliance, temper-tantrums and clinginess	136	14
8	M	Aggressive behaviour at school and home	205	10
9	F	High levels of noncompliance at school and home	203	7
10	M	Noncompliance and temper-tantrums	142	7
11	M	Aggressive behaviour mostly at kindergarten	132	10
12	F	Temper-tantrums at home	178	7

Note. M=male, F=female, ECBI=*Eyberg Child Behavior Inventory,* PBD=*Parent Behavior Diary*

Procedures

Recruitment. The researcher provided a notice (Appendix D, p.352) for schools, kindergartens, churches and local supermarkets to include in their newsletters, display on their notice boards or upload on their websites. In addition some participants were recruited by word-of-mouth from the parents who had participated in the approved initial pilot study or earlier in the present study. The same recruitment procedures used in the initial pilot study were used; however, in this study the parents were given an opportunity to nominate a place, other than the Health Sciences Clinic, to meet with the researcher. During the meeting, the parents had the opportunity to view the questionnaires. The parents were able to take the *Information Sheet* (Appendix C2, p.349) and *Consent Form* (Appendix B2, p.341) away to discuss as they wished. As shown in Figure 32 (p.180), 12 families responded to the recruitment.

Inclusion criteria. There were two inclusion criteria. First, the child was aged between 36 and 78 months at the time of recruitment. Second, the parent reported that his or

her child had behavioural problems by an elevated score (60T) in the *Intensity* scale of the ECBI.

Exclusion criteria. There were three exclusion criteria based on parent report. First, the child had debilitating physical impairment, intellectual disability or developmental delay. Second, the child was currently receiving a form of therapeutic intervention or medical treatment for the behavioural problems. Third, the parents self-reported a current mental health issue, which required medical or psychological intervention.

Screening and intake interview. The same procedures for screening and intake interviews used in the initial pilot study were used. As shown in Figure 32 (p.180)**,** a total of 12 families participated in the screening and intake interviews and three were excluded as they did not meet either the inclusion or the exclusion criteria, (a) a parent had mental health issues and was on medication and counselling; (b) a child had a mental health diagnosis and started to receive intervention in a local hospital, a week after the intake interview; (c) a child's *Intensity* score was below clinical cut-off (*T-score*=45). One family dropped out after an intake interview due to lack of child care for a 4-week-old infant.

Informed consent. The same procedure in obtaining the informed consent in Study 1 was used in this study.

Pre-intervention meeting. Apart from the same procedures used in the initial pilot study, the parent(s) met with the researcher in the observation room, after the 20-minute video-recorded play session, while the child continued playing in the playroom. He or she was asked to nominate up to three behaviours of the child to be the focus of the programme, and the researcher explained to them how to record these behaviours at home using the *Parent Behaviour Diary* (PBD, Appendix I, p.388). This took approximately 10 minutes. The date of the first session, which was to be about one to two weeks after this session

depending on the randomised baseline assigned to the parent, was determined. The total time of the session was about 60-70 minutes.

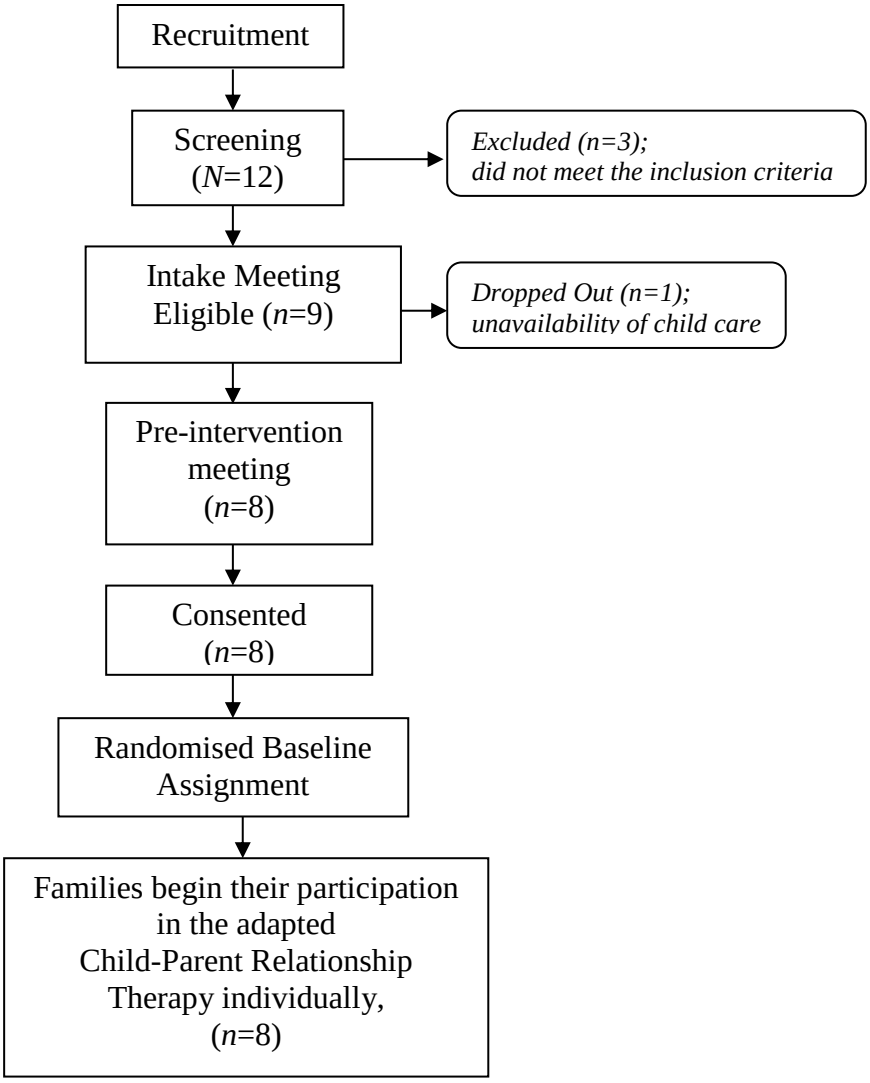


Figure 32. The flow of recruitment, screening and randomised baseline assignment

Baseline. During baseline (B), the parent was asked to record the nominated behaviours of the child for varying periods, ranging from seven to 14 days, which were randomly assigned to them. The parent was asked to draw a piece of paper from a pool of folded papers that had a number written on it which indicated the baseline days (7, 10 or 14)

for PBD. The parent was told that the intervention would not be started until there were sufficient parent records. All families received the introduction to the intervention at a different point in time, after completing the assigned baseline period.

Weekly parent-child play sessions. Weekly observation sessions on parent-child play interaction were conducted at pre-intervention meetings, across intervention, at post-intervention and Follow-up 2. The researcher set up the stage for the session with the appropriate toys and play-materials in the playroom of the School of Health Sciences Clinic or alternatively in the family's home by placing a play mat and the toys in either the living or the dining area as negotiated with the parent. Next, the parent was instructed to engage in a child-led play session with the child. The parent was directed to let the child play with any toys or activities as he or she wished for 20 minutes, while the researcher watched through a one-way mirror, and the session was video-recorded. The researcher video-recorded the sessions carried out at the participant's home with a portable video-recorder.

Intervention. The intervention was a 5-session plus booster family play-based programme. It included three clinic visits and two home visits. Each session was about a week apart, in an individual format for 60 minutes. The researcher delivered the intervention by following a structured manual prepared for the intervention. The content of each intervention session is shown in Table 14 (p.165). Additional sources of training were added in helping the parent to reconstruct his or her misperceptions toward the child in Session 1 and Session 4. In Session 2, a set of toys for the special play sessions was supplied to the parent for free and to be used in the weekly home play sessions with the child. Procedures were as in the pilot session except for a live demonstration of child-centred play sessions with the child conducted by the researcher at the participant's home in Session 3.

At each session, the parent gave the researcher the PBD, which was used to record the nominated behaviours of the child in the previous week. The records were discussed with the

parent and then the new recording forms were given to the parent. In addition, the parent was asked to play with the child for 20 minutes at the beginning of Sessions 1, 2 and 3 or alternatively a day or two before the sessions. The video-tapes were reviewed and discussed with the parent as additional feedback if needed. The parent was able to contact the researcher if he or she had questions or concerns. At the end of Session 5, the parent was given sufficient forms of the PBD to keep recording the child's behaviour for the following two weeks.

Post-intervention. Post-intervention was held a week after Session 5 at the School of Health Sciences. During the meeting, all standardised measures used in the pre-intervention meeting, included (a) ECBI, (b) *Parent Child Dysfunctional Interaction* subscale of the PSI-SF and (c) JPSCS, were again administered. The parent was then asked to engage with the child in a child-led play session for 20 minutes, and this was video-recorded. Later, the parent(s) was interviewed about their views and experiences with regard to the intervention. The parent was reminded to continue the record of the nominated child behaviours, started after the conclusion of the intervention, by completing the PBD for another week. The parent was asked to mail the completed PBD back to the researcher in a post-paid envelope, or it was collected by the researcher upon completion. This session was approximately 60 minutes, because the parent was familiar with the materials.

Follow-up 1. Follow-up 1 was held four weeks after post-intervention. The parent was once again asked to complete the ECBI. If the child's behavioural problems had worsened per score on the *Intensity* scale compared to the post-intervention's score, the parent was offered a booster session. However, all parents were entitled to attend the booster session, if they wished. It involved helping the parent to explore any difficulties they had been experiencing that interfered with their ability to implement the strategies, and reviewing the

goals and the taught strategies. This meeting took about 15 minutes, or up to 75 minutes including the booster session.

Follow-up 2. Follow-up 2 was held eight weeks after the meeting of Follow-up 1. The parent was asked to complete the ECBI and the *Parent Child Interaction* subscale of the PSI-SF in the same setting as the pre-intervention meeting, while the researcher interviewed the child using the JPSCS in another room. Then, the parent was video-taped playing with the child in a 20-minute child-led play session. The parent was again asked to record the nominated child behaviours on the PBD for the following two weeks and mail it back to the researcher in a post-paid envelope, or it was collected by the researcher upon completion. The parent was asked to keep the toys supplied to them at Session 2. The parent was thanked and the study concluded.

Settings

The same setting used in the initial pilot study was applied in this study. However, the parent(s) was given the opportunities to have Session 4 and Follow-up 1at their homes other than only at the School of Health Sciences as in the Study 1, if the parent(s) preferred. Session 3 has to be carried out at the participant's home, where a live demonstration of child-centred play session would be carried out. The Health Sciences clinic setting, including intervention rooms, the play room and the waiting room for the child, were the same as in Study 1.

Measures

A *Family Background Questionnaire* was used to obtain information about each family during the pre-intervention meeting through an interview. A set of standardised measures, which consisted of the ECBI (Eyberg & Pincus, 1999), the *Parent-Child Interaction* subscale of the PSI-SF (Abidin, 1983), and the JPSCS (Joseph, 2004), were used to determine changes in child behaviour, parental stress and child self-concept respectively, at each phase. *Parent*

Behaviour Diary was used to record changes in the child's targeted behaviour. The completion rate of the PBD was used to determine the parent's rate of homework completion.

Weekly video-recorded child-led play sessions were coded using the DPICS to assess parent and child behaviour within the intervention phase and across phases. In addition, the modified BETPT was used as a coding system to capture child metaphor play during the video-recorded child-led play sessions, if any. A *Parent Feedback Interview* (Appendix H, p.376) was conducted with each family to gain insight into the parents' experiences of the intervention as well as their perceptions about the intervention at post-intervention session.

The *Parent Child Dsyfunctional Interaction* subscale of the PSI-SF, the BETPT and the *Parent Feedback Interview* were three additional measures in the present study, which were not included in the initial pilot study. The DPICS was adapted to measure the parents' acquisition of the adapted CPRT strategies; additionally a new format of *Daily Behavioural Measures* used in Study 1, was developed for Study 2 and re-named as the *Parent Behaviour Diary*. The three additional measures, the adapted DPICS and the new format of *Daily Behavioural Measures*, namely the *Parent Behaviour Diary* were discussed as follows.

Parenting stress index-short form. The *Parent Child Dysfunctional Interaction* subscale of the PSI-Short Form (Abidin, 1983) was used to replace the *Parenting Scale* (Arnold et al., 1993) used in Study 1. This measure was selected as the items in the *Parent Child Interaction* subscale (P-CDI) are relevant to the content of the adapted model of CPRT. The PSI-Short Form (Appendix H, p.376) was developed by Abidin (1983) was widely used as anoutcome measure to determine changes in stress related to parenting after the completion of a parenting programme, including CPRT, PCIT and IY-PT (Borrego & Burrell, 2010; Lees & Ronan, 2008; Lindo, Akay, Sullivan, & Meany-Walen, 2012). Changes in parenting stress were recorded after the completion of the intervention in these studies.

The Parent Child Dysfunctional Interaction subscale consists of 12 items in a paper and pencil format checklist about parenting stress related to parent-child interactions. Eleven out of 12 items describe a parent's perception of their child in the context of parent-child interactions, for example, "My child rarely does things for me that make me feel good", and "When playing, my child doesn't often giggle or laugh." To answer these items, the parent was asked to rate them on a 5-point scale, ranging from *strongly agree* to *strongly disagree.* Item 10 in the subscale assesses parents' views of their own functioning in parenting. Parents are asked to choose a statement that best reflects their parenting function, which range from 1 (*not very good at being a parent*) to 5 (*a very good parent*). All items were scored according to the manual. Overall, the full length PSI is highly correlated with PSI-SF (.94). A high degree of alpha reliability for the *Parent-Child Dysfunctional Interaction* subscale of PSI-SF (.080) has been established. A high level of test-retest reliability was also reported on the full length PSI (.95) over a 2- week period (Abidin, 1983).

Parent behaviour diary. *Parent Behaviour Diary* (Appendix I, p.388) in the form of tally sheets was established and used by the parents to monitor their child's targeted behaviour in the present study. At the conclusion of the consent process, each parent was asked to identify up to three behavioural problems exhibited by the child and up to three positive behaviours of the child that the parent aimed to improve. Then, the parent was asked to record each occurrence of the targeted behaviour on a daily basis by marking it on the tally sheet that was given, during baseline. The parent was asked to complete the task prior to the intervention and return those forms to the researcher at the first intervention session. The parent was also asked to record the nominated behaviours of the child across the intervention phase and again for two weeks after the conclusion of the intervention and during the second follow-up phase. Data from the parent behaviour diary were entered into *Microsoft Excel* spread sheets and subsequently, the frequencies or percentages of the targeted behaviours of

the child were displayed in graphs for visual analysis. The PBD also functioned as a daily homework assignment for the parent. The percentage of the possible days the parent recorded behaviours was calculated to indicate the rate of homework completion.

Dyadic parent-child interaction coding system. All video-recorded parent-child play sessions were coded using the DPICS (Eyberg et al., 2009). In the present study, four parental responses, including *Commands* (C), *Information Questions* (IQ), *Behaviour Descriptions* (BD) and *Reflective Statements* (RF), two child responses, including *Comply* (CO) and *Answer* (AN) in the DPICS were coded at each phase, as in the pilot study. In order to use the DPICS as a direct measure, four other parental responses taught in the adapted CPRT, namely (a) *A-C-T Limit-Setting* (ACT), (b) *Esteem-Building* (EB), (c) *Positive Choices* (PC) and (d) *Choice-Giving as Consequences* (CGC), presented in the same period of times were coded using the method used in the DPICS (Appendix J) to reflect the parent's acquisition of the taught strategies and the overall changes in parent responses and child response, namely (e) *Positive Affect* (PA). The definition of each additional response of parent and child is shown in Table 16 (p.187).

Table 16

Additional Parent and Child Responses Coded using the DPICS and Their Definitions

Response	Definition and Example
A-C-T limit-setting (ACT)	A declarative phrase or statement that described the child's feeling or need followed by a clear phrase of limit toward the child's behaviour and then a statement which provides one or more alternative action(s). *"Alex, I know that you want to play with the play dough on the floor, but the floor is not for putting play dough on; the table is for putting the play dough on".*
Esteem-Building (EB)	A statement that highlighted the child's efforts or accomplishment, rather than an evaluation of a child or the child's product. "You are determined to work that out".
Positive Choices (PC)	A statement which provides two positive choices. "Alex, you can blow the trumpet softly or you can pretend to blow it".
Choice-Giving as Consequences (CGC)	A statement following the A-C-T mimit-setting that provides two possible choices and their consequences. "Alex, if you choose to play with the play dough on the table, then you choose to keep play with it. If you choose to continue to play with the play dough on the floor, then you choose not to play with the play dough for the rest of the playtime".
Child Positive Affect (PA)	Smilling, laughing, humming and singing in a happy tone, hugging, kissing, holding, rubbing the parent.

The parent's and the child's responses were coded for the second five minutes of the 20-minute play session, as according to the DPICS manual, the first five minutes of the play session are not recorded and not coded, as they serve as a warm-up period. All sessions were video-recorded and coded using the DPICS by the researcher, with 20% of them co-coded with two other PhD students from the University of Canterbury. All data generated from the coding system were presented on line graphs for visual analysis. In addition, the coded parent responses were grouped into two categories to represent two different levels of

parental control, namely (a) *directive* responses and (b) *non-directive*/*facilitative* responses, in the contex of CCPT, as shown in Table 17.

Table 17

Categories of Parent Responses Coded using DPICS

Categories	Responses
Directive	Commands (C), Informaion Questions (IQ), A-C-T Limit-Setting (ACT), Positive Choices (PC), Choice-Giving as Consequences (CGC)
Non-directive/Facilitative	Behvaioural Descriptions (BD), Reflective Statements (RF), Esteem-building (EB)

Adapted benedict's expanded themes in play therapy. An adapted *Benedict's Expanded Themes in Play Therapy* was used in the present study to capture the play behaviours or activities of the child during the weekly child-led play observation sessions and thus helped assess the child's progress in the play sessions rather than treatment effectiveness. Due to the untested validity and reliability of the modified version of BETPT, this measure was used with an explorative intention. Further explainations about this measure and the findings revealed from it were included in Appendix K (p.398).

Parent feedback interview. A semi structured interview (Appendix H, p.376) was used to explore the parent's experience in the intervention as well as their perception of the intervention. Information regarding the practicality and the effectiveness of the interventions was obtained at the post-intervention meeting through six interview questions. These were: (a) "Were there any changes that you have noticed in yourself since attending the programme?", (b) "Were there any changes that you have noticed in your child since attending the programme?", (c) "Was there a part of the programme which was particularly helpful or unhelpful for you?", (d) "Was there any part of the programme you wish had been done differently?", (e) "How would you describe this programme to others?", (f) "Do you

have any other comments regarding the programme?”. This interview took approximately 20 to 30 minutes.

Chapter 5: Results

Of the eight eligible families who participated in the research study, seven families completed both the intervention and the post-intervention assessment, while one family dropped out after Session 2 and did not take part in the post-intervention assessment. Of the seven families who completed the intervention, six of them participated in Follow-up 1 and completed the measure while one did not, Family 11. Six families took part in the second follow-up assessment and five of them completed all measures, but one, Family 12, provided partial data. Both parents in Family 7 attended the intervention. The mother was asked to complete all the measures and to conduct all the parent-child play sessions during the experimental period.

The results presented here are organised around the two overarching themes of the research questions. The first section presents data from the across-participants multiple-baseline design pertaining to the question was the adapted programme effective? This includes the behaviour diary data, ECBI, JPSCS and the *Parent-Child Dysfunctional Interaction* subscale of the PSI-SF data and the parents' improvement in child-centred play strategies, specifically on directive and non-directive responses. The second section presents data from the within-participant multiple-baseline pertaining to the question – how did the programme work? This section presents data pertaining to parent's use of the child-centred play strategies in the video-recorded parent child play session; the relationship between changes in parent's use of the child-centred play strategies in the video-recorded parent child play session and the teaching of these strategies in the curriculum; corresponding changes in children's responses in the DPICS; the adaptive changes in children's play during the DPICS over the intervention period; and data relating to changes on standardised measures for each participant.

Across-Participants Results

Child functioning.

Targeted positive behaviour. This section presents data from the across participants design pertaining to the question does the adapted CPRT lead to an improvement in targetted positive child behaviour?

The percentage of parent-reported compliance across the experimental conditions for all children was plotted in Figure 33 (p.192). At baseline, all children (*n*=7) showed low to moderate levels of compliance, with a mean compliance of 38%. When intervention occurred compliance improved for all children resulting in a mean compliance of 66% (Child 10, 14%; Child12, 34%; Child 5, 19%; Child 11, 6%; Child 8, 5%; Child 6, 63%; Child 7, 53%). At post-intervention, the average percentage of compliance was 75% across six children. Five out of six children increased further in compliance compared to that found in the intervention phase, except Child 6 whose compliance was slightly reduced but remained higher than his baseline. At Follow-up 2, an average of 66% of compliance was found in all five children.

Compliance.

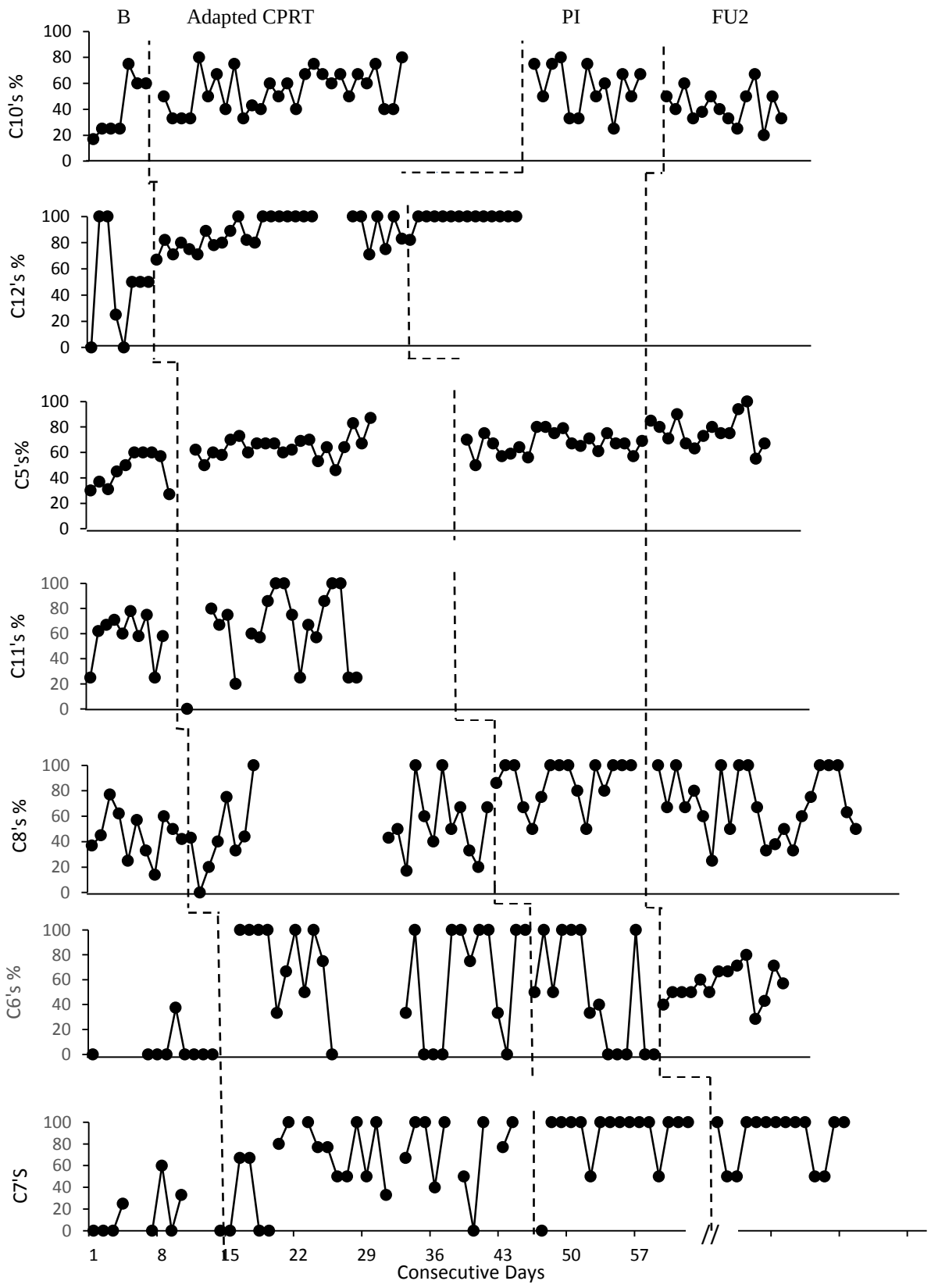


Figure 33. The percentage of parent-reported compliance across the experimental conditions for all children. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Incidents of asking appropriately.

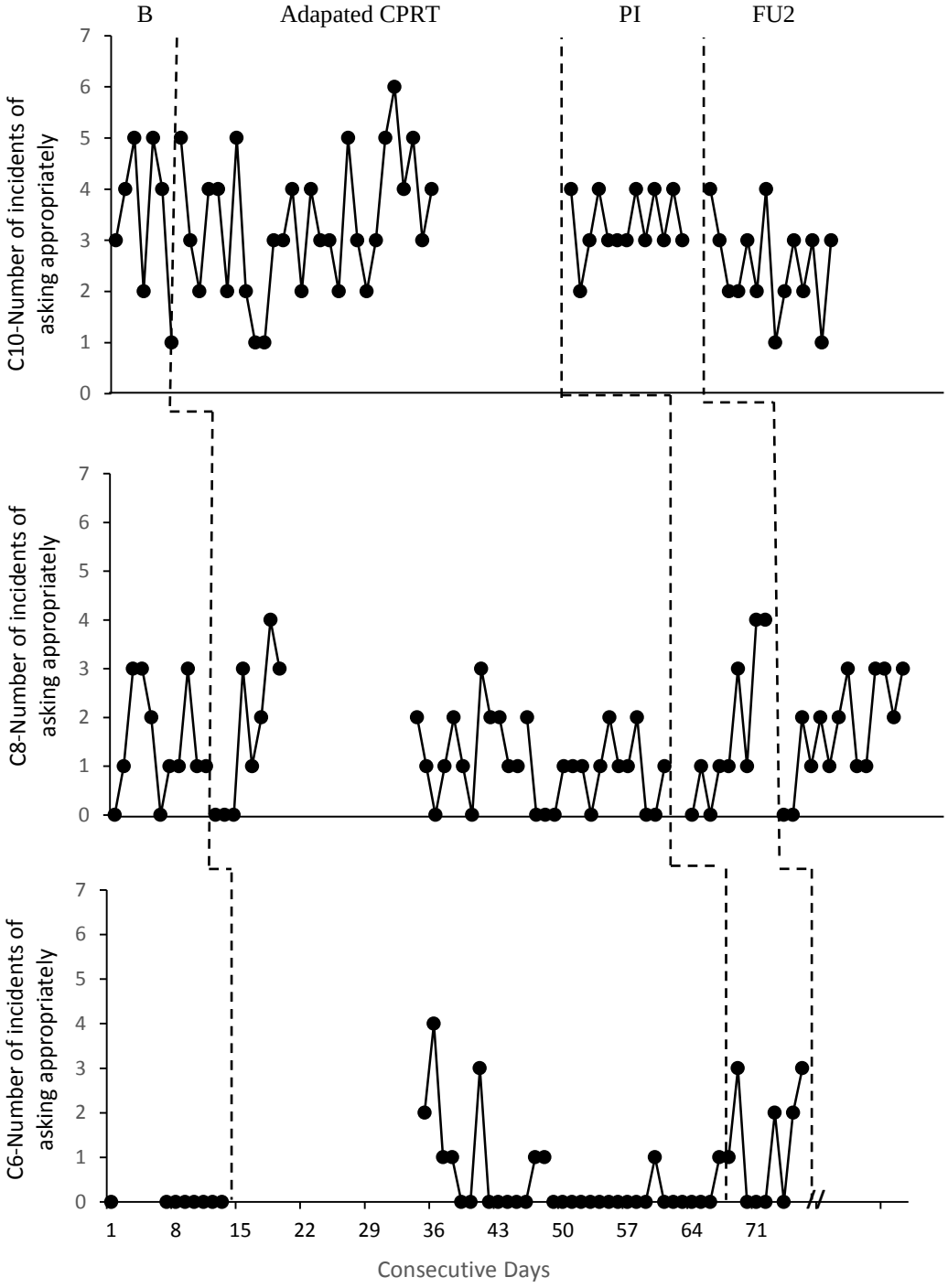


Figure 34. The number of incidents of parent-reported asking appropriately across the experimental conditions for Child 10, Child 8 and Child 6. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

The number of incidents of parent-reported asking appropriately across the experimental conditions for Child 10, Child 8 and Child 6 was shown in Figure 34 (p.193). At baseline, all parents reported low to zero levels of incidents of asking appropriately in their children. When intervention occurred, no improvement was found in Child 10 and Child 8, while a slight increase in the incidents of asking appropriately was noted in Child 6. At post-intervention, no improvement in the incidents of asking appropriately was found in Child 10 and Child 6, while a decrease was noted in Child 6, compared to their baseline. At Follow-up 2, only Child 6 showed an overall slight increment in the incidents of asking appropriately compared to his baseline, while Child 8 showed no improvement, the number of incidents of asking appropriately of Child 10 deteriorated.

Incidents of playing independently.

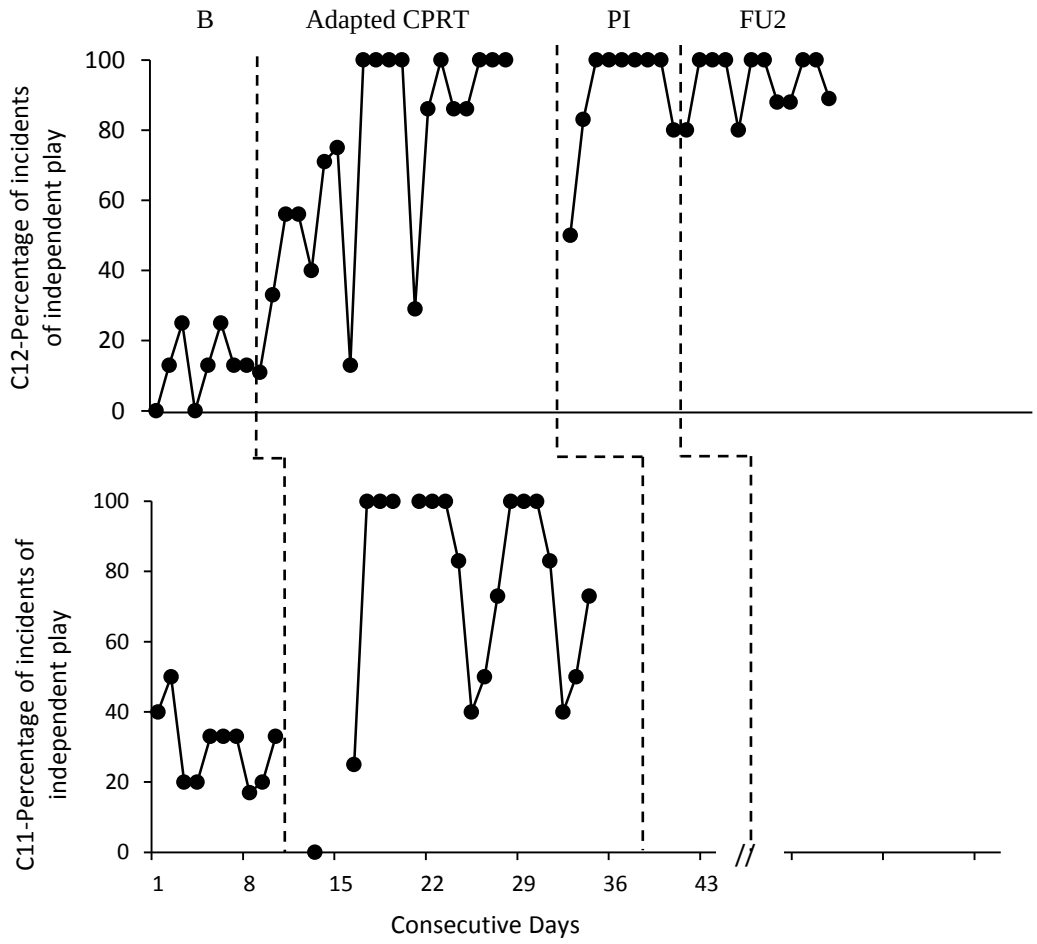


Figure 35. The percentage of incidents of parent-reported independent play across the experimental conditions for Child 12 and Child 11. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 35 depictes the percentage of incidents of parent-reported independent play across the experimental conditions for Child 12 and Child 11. At baseline, both children showed low to moderate levels of incidents of independent play of 15% and 30%, respectively. When intervention occurred, both children increased in the levels of independent play (Child 12, 77%; Child 11, 75%). The post-intervention data shown that

Child 12 continued to increase in the number of incidents of independent play and thus achieved high levels of independent play (93%).

Playing nicely with others.

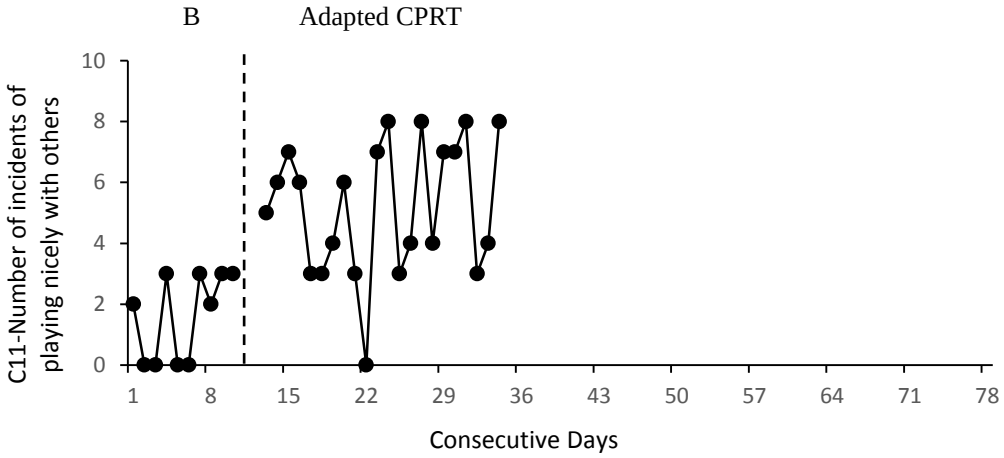


Figure 36. The number of incidents of parent-reported playing nicely with others across the experimental conditions for Child 11. *Note*. B=Baseline.

Figure 36 shows the number of incidents of parent-reported playing nicely with others across the experimental conditions for Child 11. At baseline, a low level of incidents of playing nicely with other was recorded in Child 11, with an average of 1.6 incidents per day. When, intervention occurred, there was a clear increment in the number of incidents of playing nicely with others in Child 11, with an average of 5.2 incidents daily. Parent 11 did not report the child's behaviour after the completion of the intervention.

Put toys away.

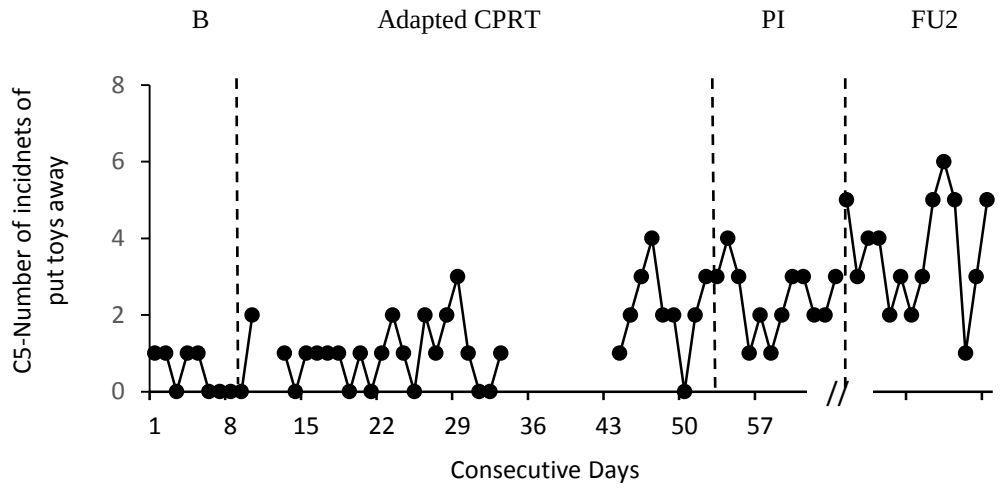


Figure 37. The number of incidents of parent-reported put toys away across the experimental conditions for Child 5. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 37 shows the number of incidents of parent-reported put toys away across the experimental conditions for Child 5. At baseline, Child 5 showed low frequency in the incidents of put toys away, with a mean of one incident per day. When intervention occurred, no improvement was noted in Child 5. However, there was an increasing trend in the incidents of put toys away in Child 5 from post-intervention, with an average of 2.25 incidents daily, to Follow-up 2, with an average of four incidents per day.

Targeted negative behaviour. This section presents data from the across participants design pertain to the question does the adapted CPRT lead to a reduction in negative child behaviour?

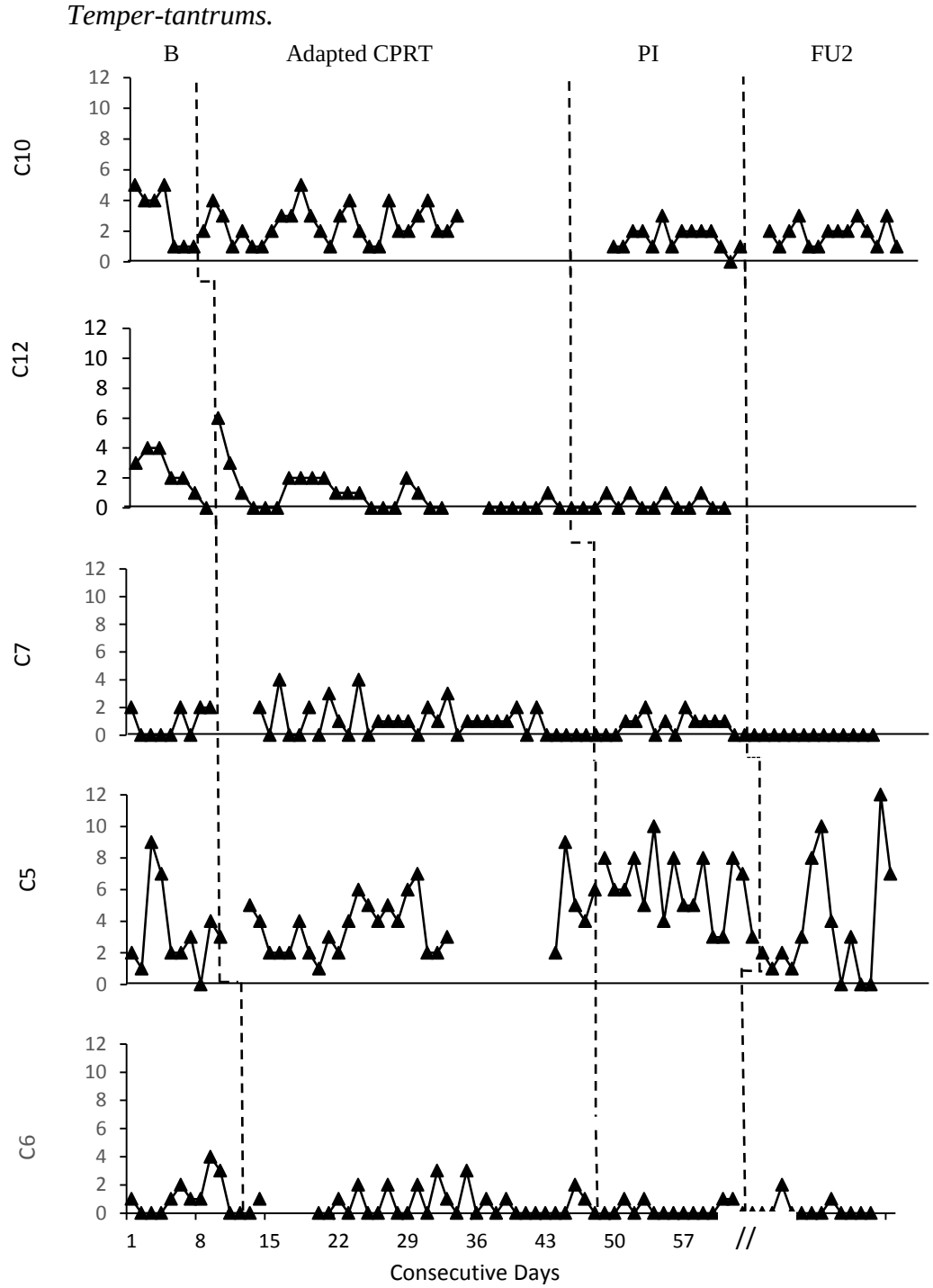


Figure 38. The number of incidents of parent-reported temper-tantrums across the experimental conditions for Child 10, Child 12, Child 7, Child 5 and Child 6. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

The number of incidents of parent-reported temper-tantrums across the experimental conditions for Child 10, Child 12, Child 7, Child 5 and Child 6 was plotted in Figure 38 (p.198). At baseline, an average low level of incidents of temper-tantrums was found across children, with an overage of 2.1 incidents per day at baseline. The number of incidents of temper-tantrums of four out of five children was highly fluctuated, except Child 9, who shown consistently low levels of incidents of temper-tantrums. When intervention occurred, Child 12 clearly decreased in the number of incidents of temper-tantrums, while Child 5 showed increment. Other children showed subtle decrease in the number of incidents of temper-tantrums. At post-intervention, three out of five children showed noticeable reductions in the number of incidents of temper-tantrums. While Child 7 showed subtle reduction in the number of incidents of temper-tantrums, Child 5 continued to deteriorate and showed an overall higher level of incidents of temper-tantrums. At Follow-up 2, data was available only for four children. Of that, three out of four children showed noticeable reduction, while one child, Child 5, showed increment in the number of incidents of temper-tantrums compared to he had in baseline.

Attention seeking.

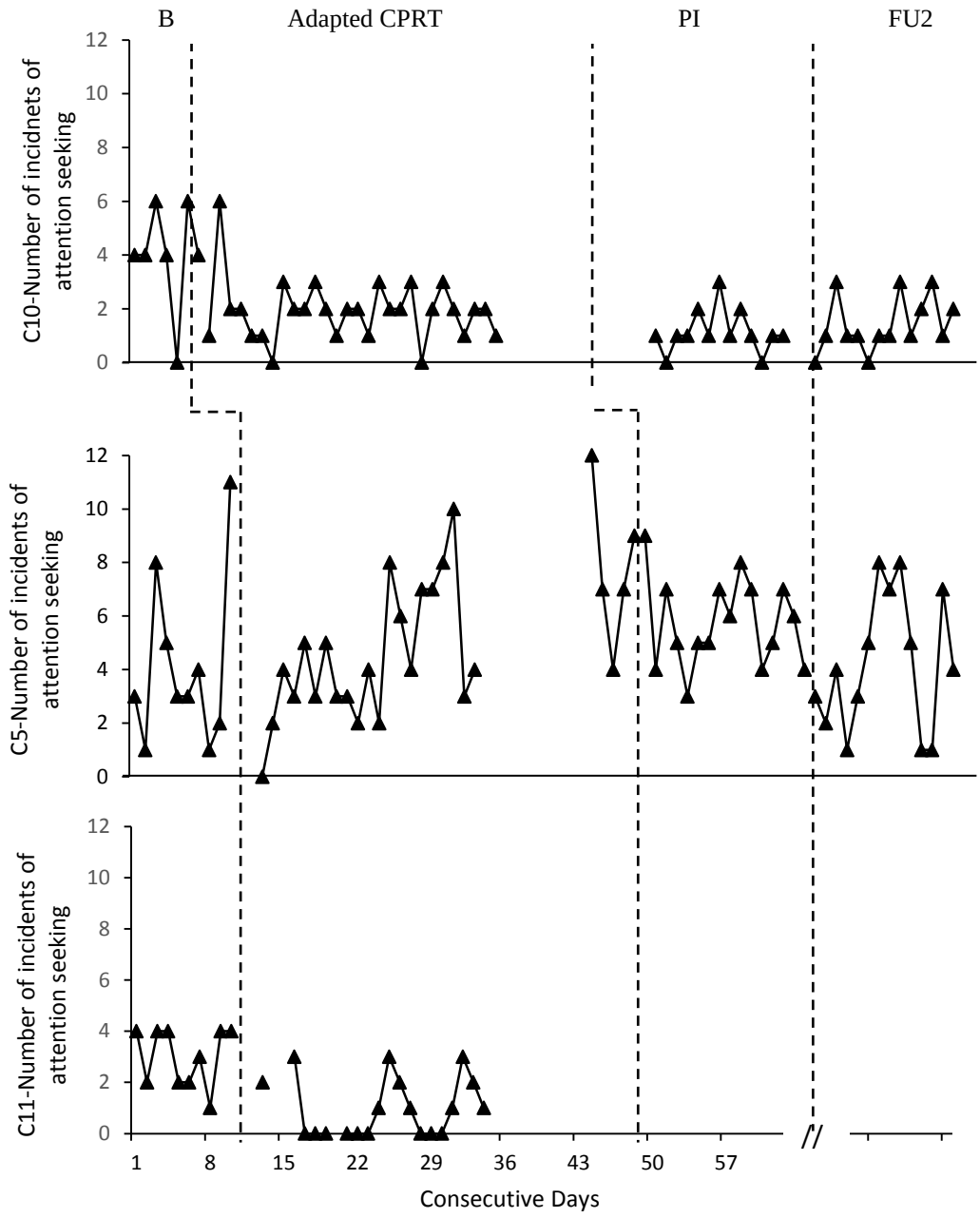


Figure 39. The number of incidents of parent-reported attention seeking across the experimental conditions for Child 10, Child 5 and Child 11. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 39 shows the number of incidents of parent-reported attention seeking across the experimental conditions for Child 10, Child 5 and Child 11. At baseline, there was a moderate level of incidents of attention seeking across children; however the number of

incidents of attention seeking of Child 5 was highly fluactuated between low and high rates. When intervention occurred, the number of incidents of parent-reported attention seeking of two out of three children, Child 10 and Child 11, largely reduced compared to they had in baseline. The number of incidents of attention seeking of Child 10 continued to reduce further in post-intervention and Follow-up 2. On the other hand, the number of incidents of parent-reported attention seeking of Child 5 increased further during the intervention phases and again at post-intervention compared to his had in baseline. It eventually returned to it baseline's levels at Follow-up 2.

Aggression.

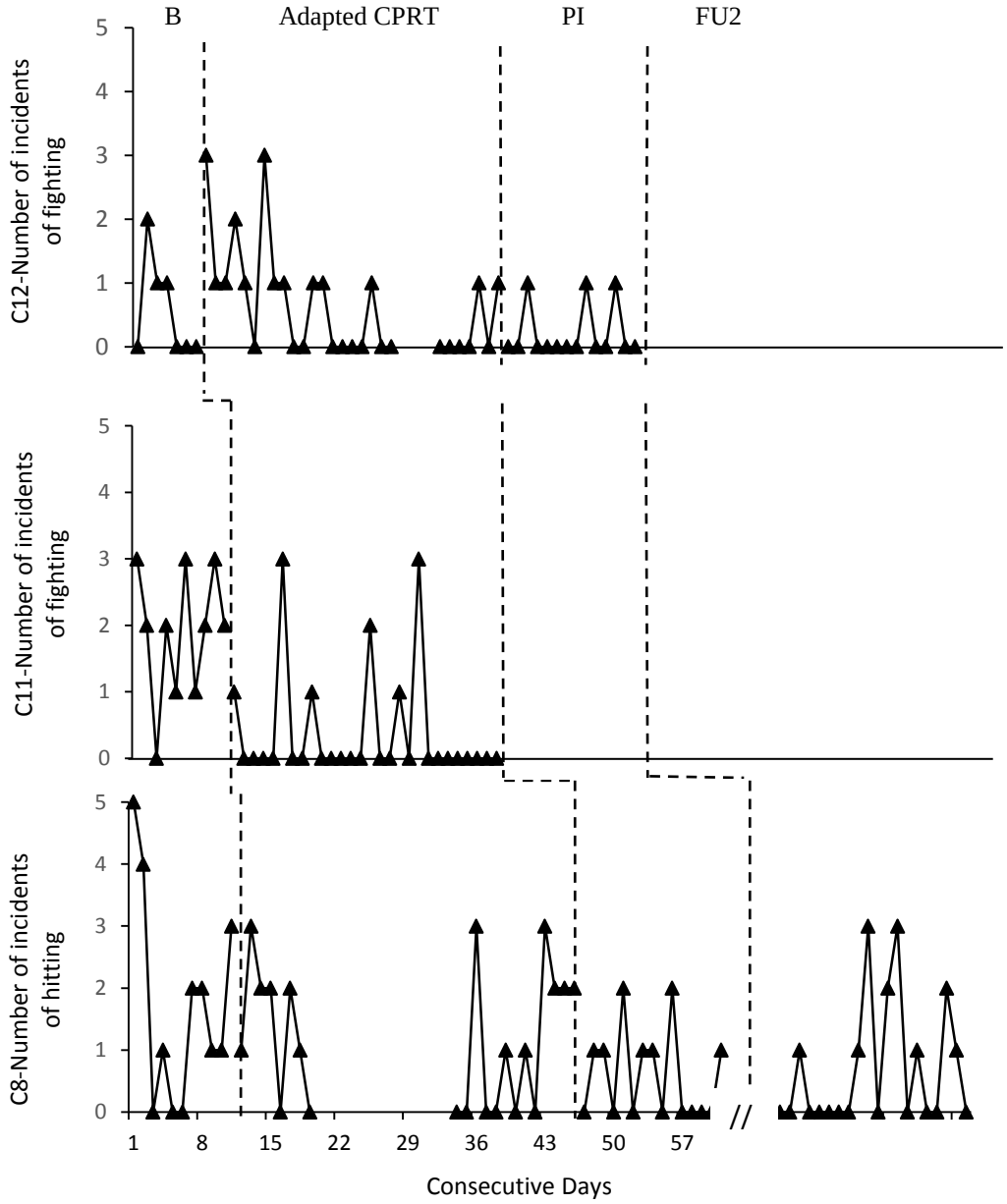


Figure 40. The number of incidents of parent-reported aggression across the experimental conditions for Child 12, Child 11 and Child 8. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 40 shows the number of incidents of parent-reported aggression across the experimental conditions for Child 12, Child 11 and Child 8. At baseline, Child 12 showed low levels of aggression, with an average of 0.6 incidents per day; Child 12 showed moderate

levels of aggression, with an average of 1.9 incidents per day; Child 8 showed a high variation in the number of incidents of aggression, with an average of 1.7 incidents per day. When intervention occurred, only Child 11 showed a noticeable reduction in the number of incidents of aggression, which was not found in the other two children. Post-intervention data was available for two children and both of them showed lower levels of parent-reported aggression as compared to they had in baseline.

Interruption.

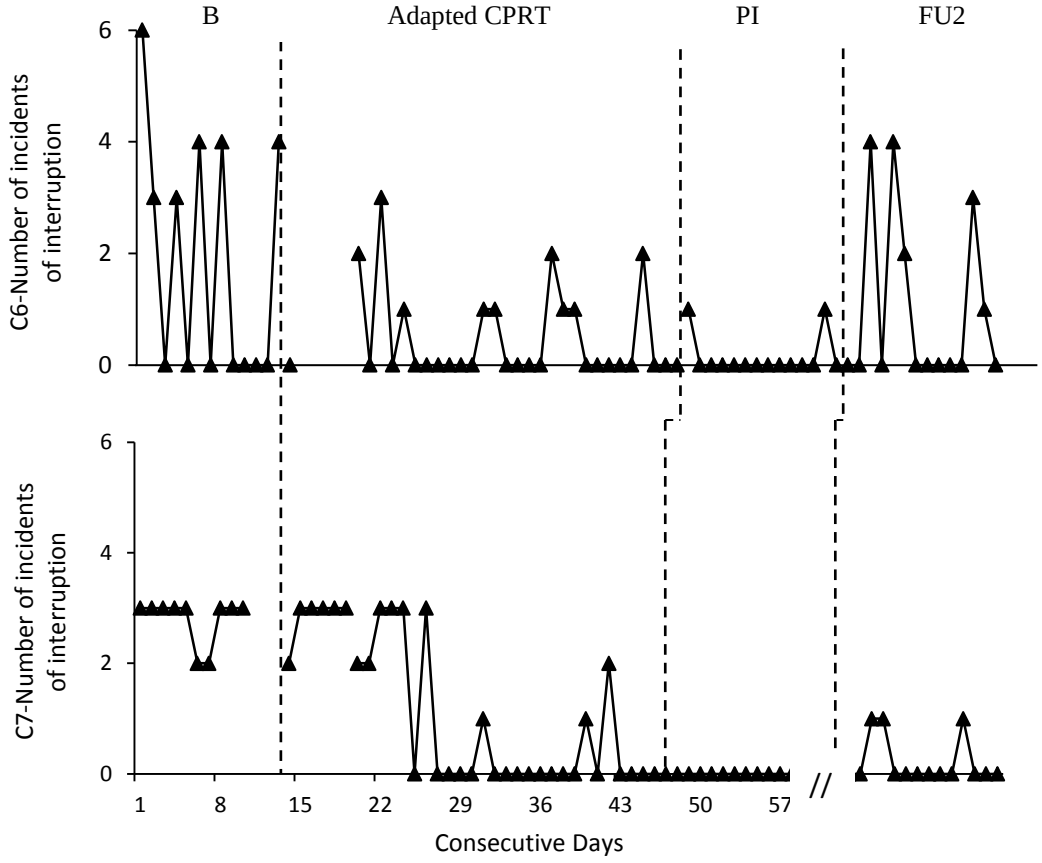


Figure 41. The number of incidents of parent-reported interruption across the experimental conditions for Child 6 and Child 7. *Note.* B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 41 (p.203) shows the number of incidents of parent-reported interruption across the experimental conditions for Child 6 and Child 7. At baseline, both children showed low to moderate levels of interruption, with an average of 2.3 incidents per day. When intervention occurred, a clear reduction in the number of incidents of interruption was noted in both children, with an overage of 0.6 incidents per day. At post-intervention, both children were reported with a further reduction in the number of incidents of interruption, where it was not evident in most of the days. At Follow-up 2, both children showed lower levels of incidents of interruption compared to they had in baseline (C6, *M*=1; C7, *M*=0.2).

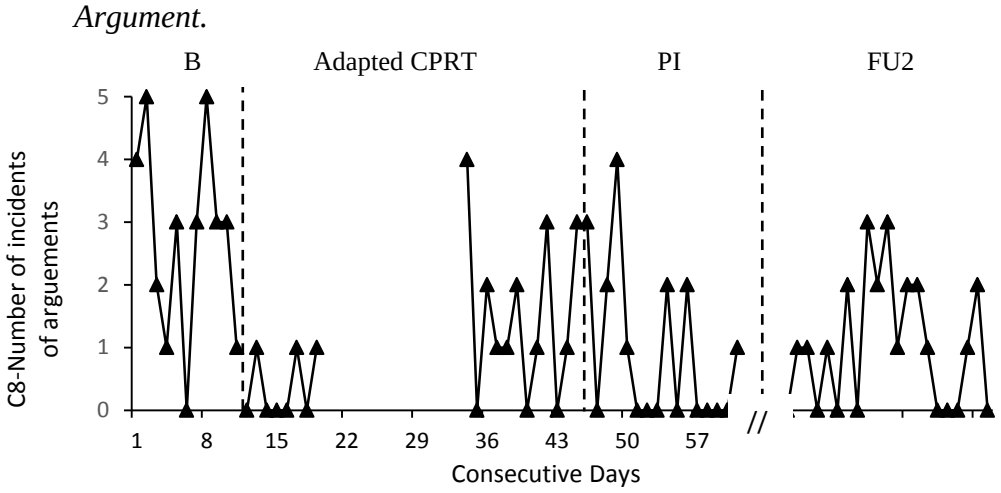


Figure 42. The number of incidents of parent-reported argument across the experimental conditions for Child 8. *Note*. B=Baseline; PI=Post-intervention; FU2=Follow-up 2.

Figure 42 shows the number of incidents of parent-reported argument across the experimental conditions for Child 8. At baseline, a high variation of incidents of argument was reported for Child 8, with an average of 2.7 incidents per day. When intervention occurred, there was an overall reduction in the incidents of argument initiated by Child 8, with an average of one incident per day. This improvement remained stable at post-

intervention and Follow-up 2, with an average of less than one incident per day in both phases.

Parent-reported of child behavioural problems. This section presents data from the across participants design pertaining to the question does the adapted CPRT lead to an overall reduction in parent-reported of child behaviour problems? The results of ECBI at baseline, post-intervention, first and second follow-ups across participants are shown in Table 18.

Table 18

The Results of the ECBI at baseline, post-intervention, first and second follow-up across children

Child	Baseline	PI	FU1	FU2
5	140 (**62**)	125 (58)	132 (**60**)	83 (46)
6	146 (**64**)	152 (**66**)	146 (**64**)	129 (59)
7	136 (**61**)	111 (54)	90 (48)	78 (45)
8	205 (**81**)	139 (**62**)	108 (53)	107 (53)
9	203 (**80**)	-	-	-
10	142 (**63**)	82 (46)	65 (41)	126 (58)
11	132 (**60**)	108 (53)	-	-
12	178 (**73**)	109 (54)	98 (50)	59 (39)

Note. Raw scores are presented. Data in parentheses are T-scores; scores 60 and above denote clinical significance and are shown in bold. – =data was unavailable as the participant discontinued the study. PI=Post-intervention; FU1=Follow-up 1; FU2 =Follow-up 2.

Aligning with the inclusion criterion, as shown in Table 18, all children were rated by their parents in the clinically significant range for the intensity of their behavioural problems at baseline, with an average *T-score* of 68. At post-intervention, the average *T-score* was 56.14, with five out of seven children rated in the normative range for the intensity of their behavioural problems; however two children's ratings (Child 6 and Child 8) remained in the clinically significant range. At Follow-up 1, the average *T-scores* were 52.67, with four out of six children's ratings in the normative range for the intensity of their behavioural problems, while one child's (Child 6) rating remained in the clinically significant range and the other

child's (Child 5) rating was on the cut-off for clinical significance (i.e., *T*=60). At Follow-up 2, all children were rated by their mothers as being in the normative range for the intensity of their behavioural problems with average *T-scores* of 50; a further reduction in ratings was found in four out of six children, including Child 5 and Child 6.

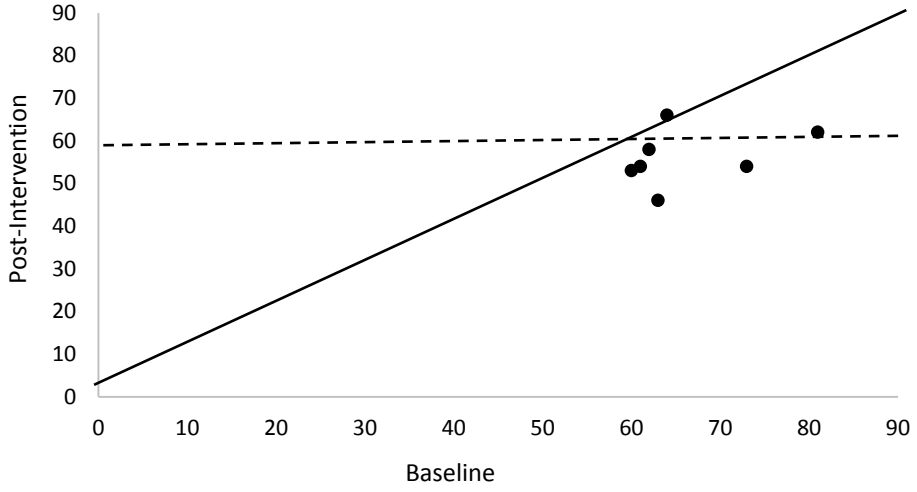


Figure 43. Scatterplot of Baseline to Post-intervention Effects for ECBI Intensity Scores
The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who experienced a deterioration in scores. The dash line indicates the clinical cut-off

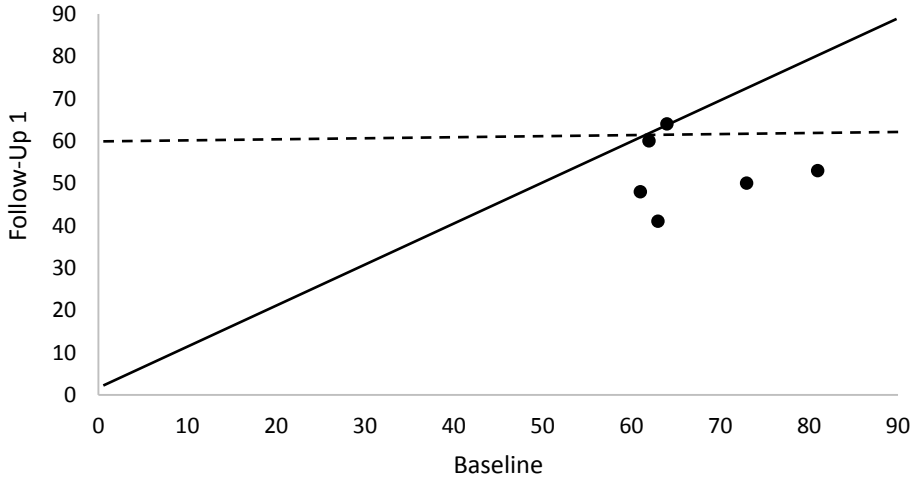


Figure 44. Scatterplot of Baseline to Follow-up 1 Effects for ECBI Intensity Scores
The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who experienced a deterioration in scores. The dash line indicates the clinical cut-off

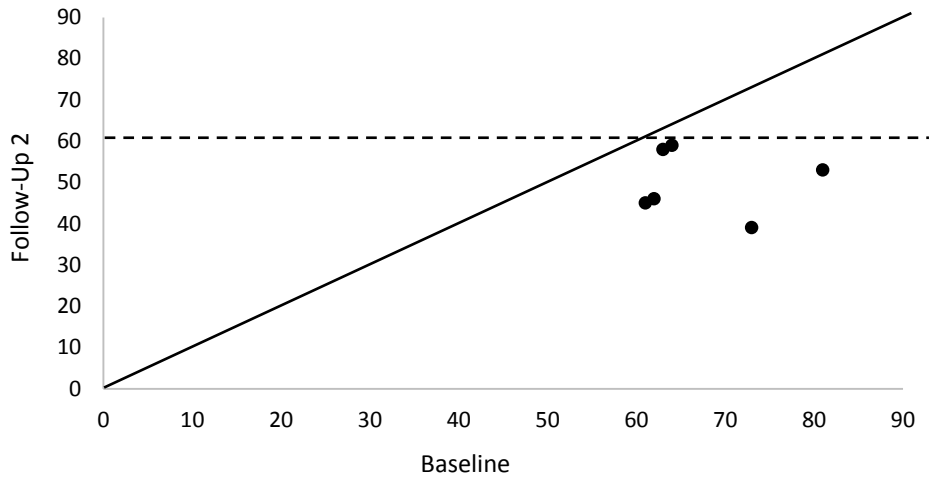


Figure 45. Scatterplot of Baseline to Follow-up 2 Effects for ECBI Intensity Scores
The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who experienced a deterioration in scores. The dash line indicates the clinical cut-off

Figure 43, 44 and 45 represent scatterplots of post-intervention, Follow-up 1 and Follow-up 2 effects, respectively, for the ECBI *Intensity* scores. Child behavioural intensity at post-intervention demonstrated improvement in six out of seven parent ratings on the ECBI *Intensity* scale (Figure43, p.206). At follow-up 1, five out of six children's intensity scores indicated improvement compared to baseline(Figure 44, p.206). At Follow-up 1, all six children's intensity scores indicated improvement compared to baseline (Figure 45, p.207).

Children's reports of self-concept. This section presents data pertaining to the question "Does the adapted CPRT lead to an improvement in child-reported self-concept across the participants?" The results of the JPSCS at baseline, post-intervention and Follow-up 2 across children are shown in Table 19 (p.208).

Table 19

The results of the JPSCS at baseline, post-intervention and follow-up 2 across children

	Baseline	PI	FU2
5	54 (MP)	54 (MP)	73 (MP)
6	8 (HN)	73 (MP)	90 (HP)
7	73 (MP)	90 (HP)	90 (HP)
8*	<1 (VN)	<1 (VN)	4 (HN)
9	54 (MP)	-	-
10	90 (HP)	54 (MP)	73 (MP)
11	54 (MP)	73 (MP)	-
12	3 (VN)	16 (P)	-

Note. Percentile scores are presented, ranging from <1 to 90, with no clinical cut-off scores. Codes in parentheses represent self-concept classification, High Positive (HP), Moderate Positive (MP), Poor (P), High-Risk Negative (HN) and Very High-Risk Negative (VN). * denotes child aged between 72-month and 95-month; different JPSCS scores relate to the same categories of self-concept in the younger age-group. – =data was unavailable as the participant dropped out from the study; PI=Post-intervention; FU2=Follow-up 2.

At baseline, three out of eight children's JPSCS ratings were either in the classification of *high-risk negative* or *very high-risk negative* self-concept, while the other five's ratings were in the classification of *moderate positive* or *high positive* self-concept, with an average percentile score of 42. At post-intervention, an average percentile score of 51 was found among seven children. Of that, four out of seven children's JPSCS ratings increased, two children's ratings remained unchanged and one child's rating deteriorated. At Follow-up 2, an average percentile score of 66 was found among five children. Of that, four out of five children rated themselves higher on JPSCS than they had in baseline, except Child 10, whose score deteriorated. Four out of five children's JPSCS ratings increased further compared to their post-intervention's ratings, including Child 10, while Child 7's score remained unchanged. In addition, all children's JPSCS ratings were in the classification of *moderate positive* and *high positive*, with the exception of Child 8, whose rating was increased

(i.e., improvement) but was in the classification of *high-risk negative* self-concept.

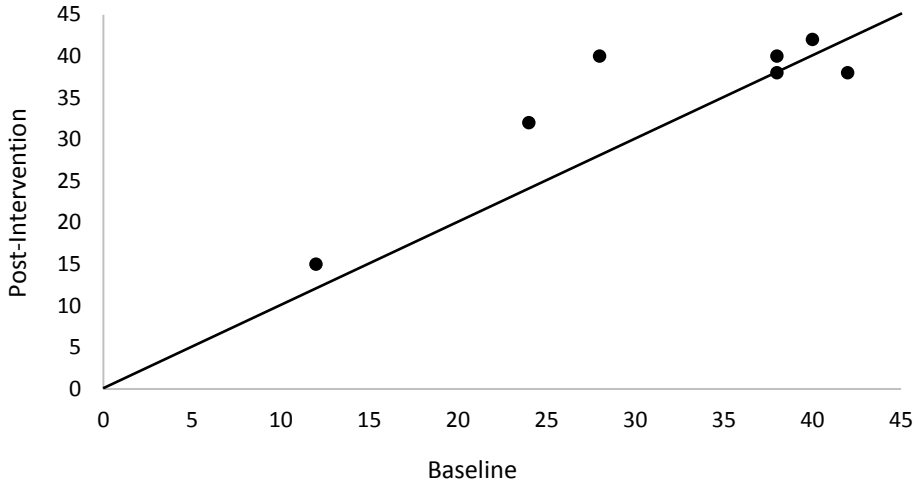


Figure 46. Scatterplot of Baseline to Post-intervention Effects for JPSCS Raw Scores *The markers above the linear line represent participants who improved, over the phases while markers below the linear line represent participants who experienced a deterioration in scores*

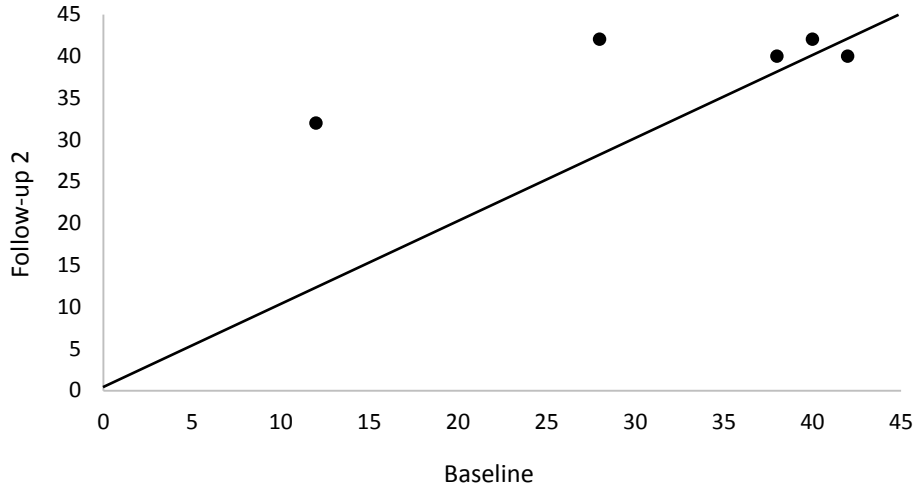


Figure 47. Scatterplot of Baseline to Follow-up 2 Effects for JPSCS Raw Scores *The markers above the linear line represent participants who improved, over the phases while markers below the linear line represent participants who experienced a deterioration in scores*

Figure 46 and 47 represent scatterplots of the post-intervention and Follow-up 2 effects, respectively, for the JPSCS raw scores. Child self-concept at post intervention

(Figure 46, p.209) demonstrated improvement in five out of seven children's ratings, one child's rating was unchanged while another's rating deteriorated. At Follow-up 2 (Figure 47, p.209), four out of five children's JPSCS ratings indicated improvement compared to baseline.

Parents' outcomes. This section pertaining to two research questions, "Does the adapted CPRT lead to a reduction in parenting stress across the participants?"; and "Does the adapted CPRT lead to an increase in parent's use of the child-centred play strategies in the video-recorded parent child play sessions?"

Parenting stress related to parent-child dysfunctional intercation. The results of *Parent-Child Dsyfunctional Interaction subscale* of the PSI-SF at baseline, post-intervention and Follow-up 2 across parents are shown in Table 20 and on Figures 48 (p.211) and Fingure 49 (p.212).

Table 20

The Results of the Parent-Child Dysfunctional Interaction Subscale at Baseline, Post-Intervention and Follow-up 2 across Parents

Parent	Baseline	PI	FU2
5	31(**80**)	28(72)	18(32)
6	29(76)	31(**80**)	20(42)
7	28(72)	27(70)	26(66)
8	34(**86**)	29(76)	27(70)
9	25(62)	-	-
10	24(58)	17(28)	17(28)
11	18(32)	14(14)	-
12	24(58)	15(18)	13(10)

Note. Raw scores are presented. Data in parentheses are percentile scores; 80 to 84 denote borderline, 85 and above denote clinical significance and are shown in bold. – =data is unavailable as the participant discontinued the study; PI =Post-intervention; FU2 =Follow-up 2.

At baseline (Table 20, p.210), two parents' ratings (Parents 5 and 8), were in the borderline or clinical significance range of stress, while the other six ratings were within the normal range; the average *Parent-Child Dsyfunctional Interaction* raw score was 23.38 for all eight parents. After the completion of the intervention, the average *Parent-Child Dsyfunctional Interaction* raw score was 20; all parent ratings were in the normal range of stress, with the exception of Parent 6, who rated herself in the clinically significant range. At Follow-up 2, the average *Parent-Child Dsyfunctional Interaction* raw score was 18 for all six parent ratings and all ratings were in the normal range. In addition, five out of six parent ratings reduced further from their post-intervention's ratings, while one parent (Parent 10) retained her post-intervention gains.

Figure 48 and 49 represent scatterplots of the post-intervention and Follow-up 2 effects, respectively, for the P-CDI sub-scores.

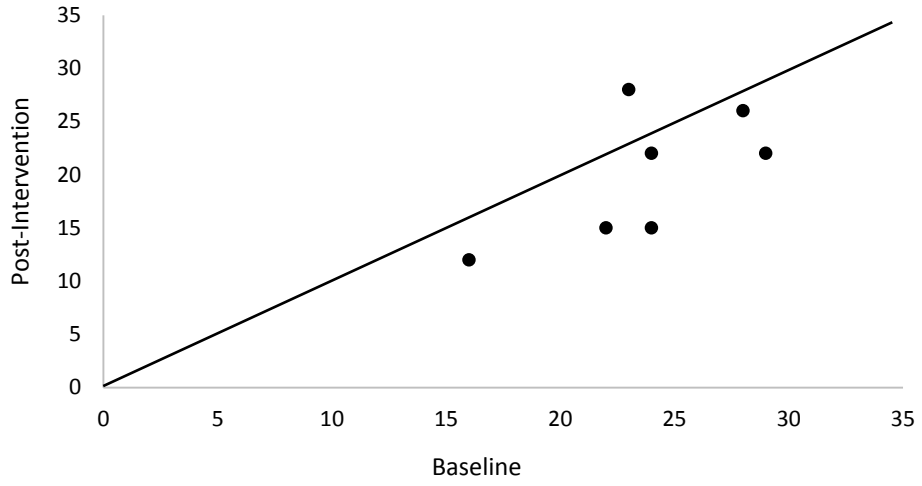


Figure 48. Scatterplot of Baseline to Post-intervention Effects for P-CDI Raw Scores
The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who experienced a deterioration in scores

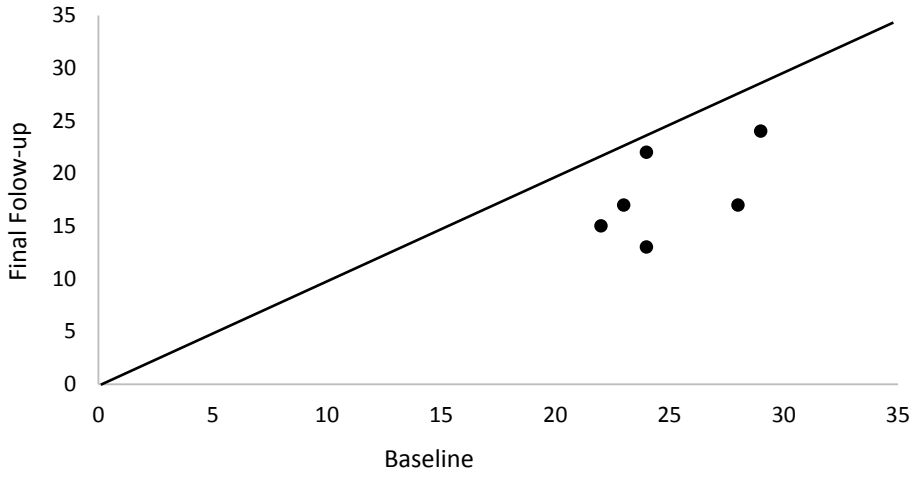


Figure 49. Scatterplot of Baseline to Follow-up 2 Effects for P-CDI Raw Scores
The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who experienced deterioration in scores

Parenting stress related to parent-child dysfunctional interaction at post-intervention (Figure 48, p.211) demonstrated improvement in six out of seven parent ratings on P-CDI. At Follow-up 2 (Figure 49), all six parent ratings indicated reductions in parenting stress related to parent-child dysfunctional interaction compared to the baseline.

Observed parental responses during play sessions.

Directive response. Figure 50 and 51 represent scatterplots of the post-intervention and Follow-up 2 effects, respectively, for the parent's observed directive response.

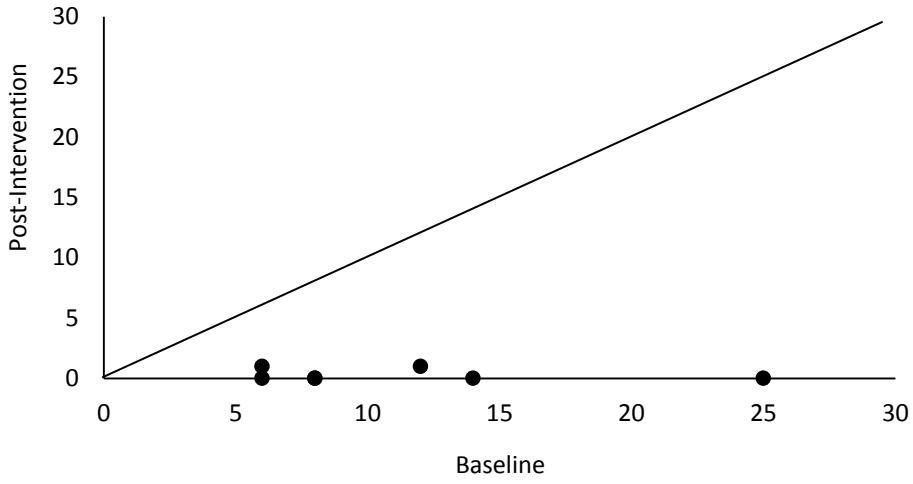


Figure 50. Scatterplot of Baseline to Post-intervention Effects for the Parent's Observed Directive Response. *The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who deteriorated*

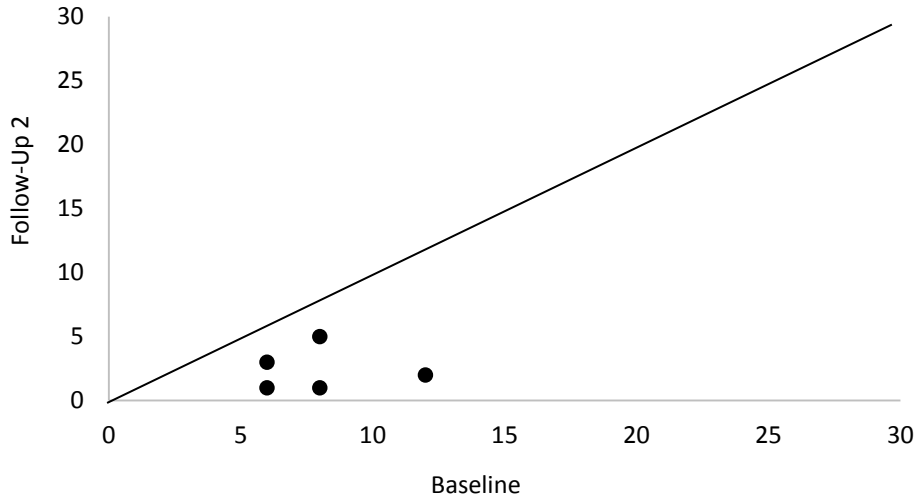


Figure 51. Scatterplot of Baseline to Follow-up 2 Effects for the Parent's Observed Directive Response. *The markers below the linear line represent participants who improved, over the phases while markers above the linear line represent participants who deteriorated*

Parental-directed response at post-intervention (Figure 50, p.213) demonstrated improvement in all parents. At Follow-up 2, (Figure 51, p.213), all five parents' DPICS results indicated improvement compared to baseline.

Non-directive response. Figure 52 and 53 (p.215) represent scatterplots of the post-intervention and Follow-up 2 effects, respectively, for the parent's observed non-directive response.

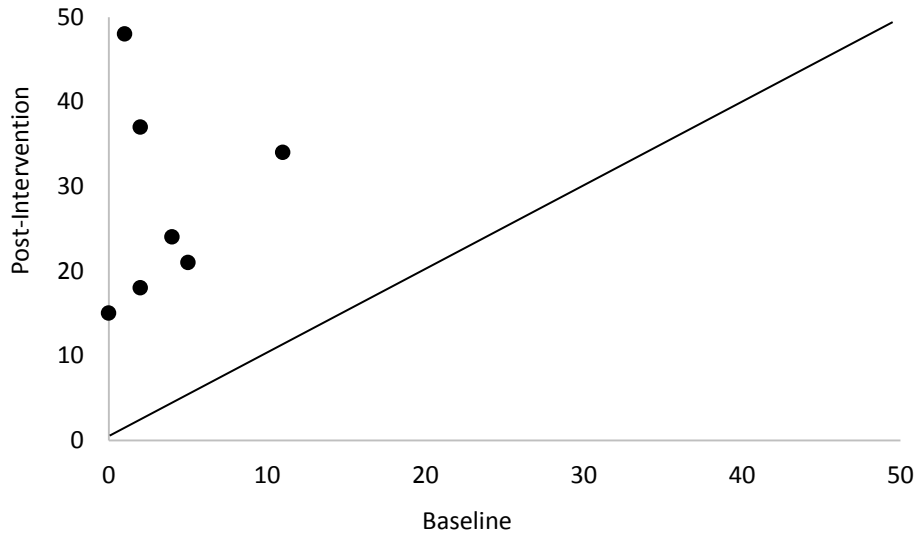


Figure 52. Scatterplot of Baseline to Post-Intervention Effects for the Parent's Observed Non-directive Response. *The markers above the linear line represent participants who improved, over the phases while markers below the linear line represent participants who deteriorated*

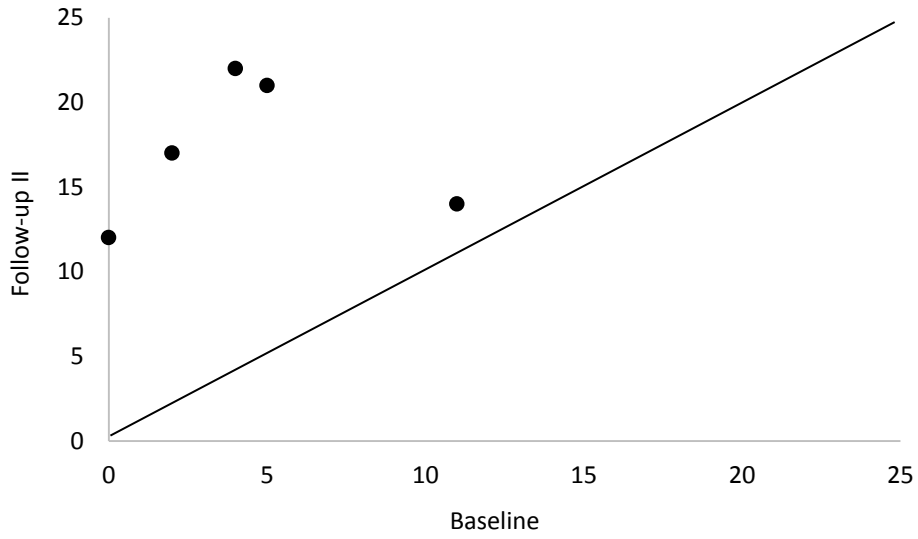


Figure 53. Scatterplot of Baseline to Follow-up 2 Effects for the Parent's Observed Non-directive Response. *The markers above the linear line represent participants who improved, over the phases while markers below the linear line represent participants who deteriorated*

Parental non-directed response at post-intervention (Figure 52, p.214) demonstrated improvement in all seven parents. At Follow-up 2 (Figure 53), all five parents' DPICS results indicated improvement compared to baseline.

Parents' feedback on the adapted CPRT. This section summarised six parents' feedback on the adapted CPRT, collected using *Parent Feedback Interview*. All parents gave positive comments about the programme. Generally, the parents thought the programme was "helpful", "positive and beneficial", "great" and "fantastic". Five of them indicated that since attending the programme, they had been feeling "less stressed ", "more relaxed" or "calmer"; four parents indicated that they hade been "more confident" and two parents thought that they had been more understanding regarding their child's behaviours, emotions and intentions. All parents indicated that since attending the programme, their child had shown more positive behaviour, including compliance , politeness, patience , independence and talking more openly, while showing fewer negative behaviours, including temper-tantrums, and aggression. Two parents indicated that their child had been "happier" since. Three parents

thought that the live demonstration of the child-centred play sessions with the targeted child, by the intervention provider, was the most helpful part of the programme. In terms of strategies, five parents indicated that *reflection* of emotions and behaviour tracking were most helpful for them, while one parent thought that *A-C-T limit-setting* was most helpful. Four of out six parents said that they would not change a thing in the programme, while one parent wished to have more live demonstration of the child-centred play sessions with the targeted child by the intervention provider, and another parent suggested including more blank pages in the intervention booklet for note taking. The parents described the programme as teaching them "a positive way of interaction" with their children and "how to restore a positive family relationship" by helping them "to relate to", "to listen and understand" their child's feelings and emotions, and to better understand themselves as a parent. Three parents said they would "love" to see the Ministry of Education to use this programme, especially in schools and preschools and even offered it for parents as weekend workshops. One parent said that she would "highly recommended it to all parents and teachers working in ECE…it should become part of the Bachelor's Degree in Early Childhood Education".

Summary of the Across-Participants' Results

In parent-recorded child positive behaviours on PBD, all seven children improved in their compliance, both during and after intervention. One out of three children improved in asking appropriately; two out of two children increased in playing independently, and each child measured improved in playing nicely with others and in putting toys away. In parent recorded child negative behaviours on PBD, improvement in temper-tantrum was found in one out of five during intervention, four out of five children during post-intervention and three out of four children during Follow-up 2. Reductions in attention seeking was evident in two out of three children during intervention, one reduced across post-intervention and another reduced during Follow-up 2. Reductions in aggression were found in one out of three

children during intervention, two out of two children reduced in aggression at post-intervention and Follow-up 2. Improved in interruption was shown in all two children during and after the intervention. One out of one child reduced in the incidents of argument during and after the intervention.

On implementation of the intervention, all children demonstrated improvement in behaviour on ECBI and this was maintained for five of them at Follow-up 1 and for four of them at follow-up 2. All six children showed further improvement at Follow-up 2 where their *Intensity* scores reduced to non-clinical levels. For child self-concept, four children demonstrated improvement on JPSCS at post-intervention (out of seven) and at Follow-up 2 (out of five). For parental stress related to parent-child interaction, all seven parents demonstrated improvement on the *Parent-Child Dsyfunctional Interaction* subscale of the PSI-SF at post-intervention; two out of two parents showed clinically significant change at post-intervention and this was maintained at Follow-up 2. In terms of observed parent responses during play sessions, all parents demonstrated improvement in non-directive and directive responses at post-intervention (n=7) and follow-up 2 (n=5).

Within-Participant Results

This section presents data pertaining to the following questions, "What is the relationship between any changes in the parents' use of the child-centred play strategies in the video-recorded parent child play session and the teaching of these strategies in the curriculum?"; "Are there corresponding changes in children's responses during the video-recorded parent child play sessions?"; "Does the adapted CPRT lead to a reduction in parenting stress across the participants?" Then, the findings of parent and child functioning on standardised measures were presented.

Family 5.

Observed parent responses across phases. Parent 5's DPICS responses across the phases are displayed in Figure 54. There was improvement evident across the phases in three out of the eight strategies, including *reflective statements*, *behavioural descriptions* and *esteem-building* responses.

Skills taught in Session 1.

Reflective statements. At Baseline, Parent 5 made few *reflective statements*. There was a decrease in the use of *reflective statements* from Baseline (*n*=4) to Session 1 (*n*=2). This was followed by an improvement in the use of *reflective statements* from Session 2 (*n*=8) which continued up to Follow-up 2 (*n*=11), with the exception in Session 4 (*n*=4).

Skills taught in Session 2.

Behavioural descriptions. At Baseline, Parent 5 showed low rates of *behavioural descriptions* (*n*=1 & 0). *Behavioural descriptions* were low and stable across the baseline measures and they were no change from baseline to Session 2 (*n*=2). This was followed by an improvement in the use of *behavioural descriptions* from Session 3 (*n*=13) which continued until post-intervention (*n*=15) and further at Follow-up 2 (*n*=7).

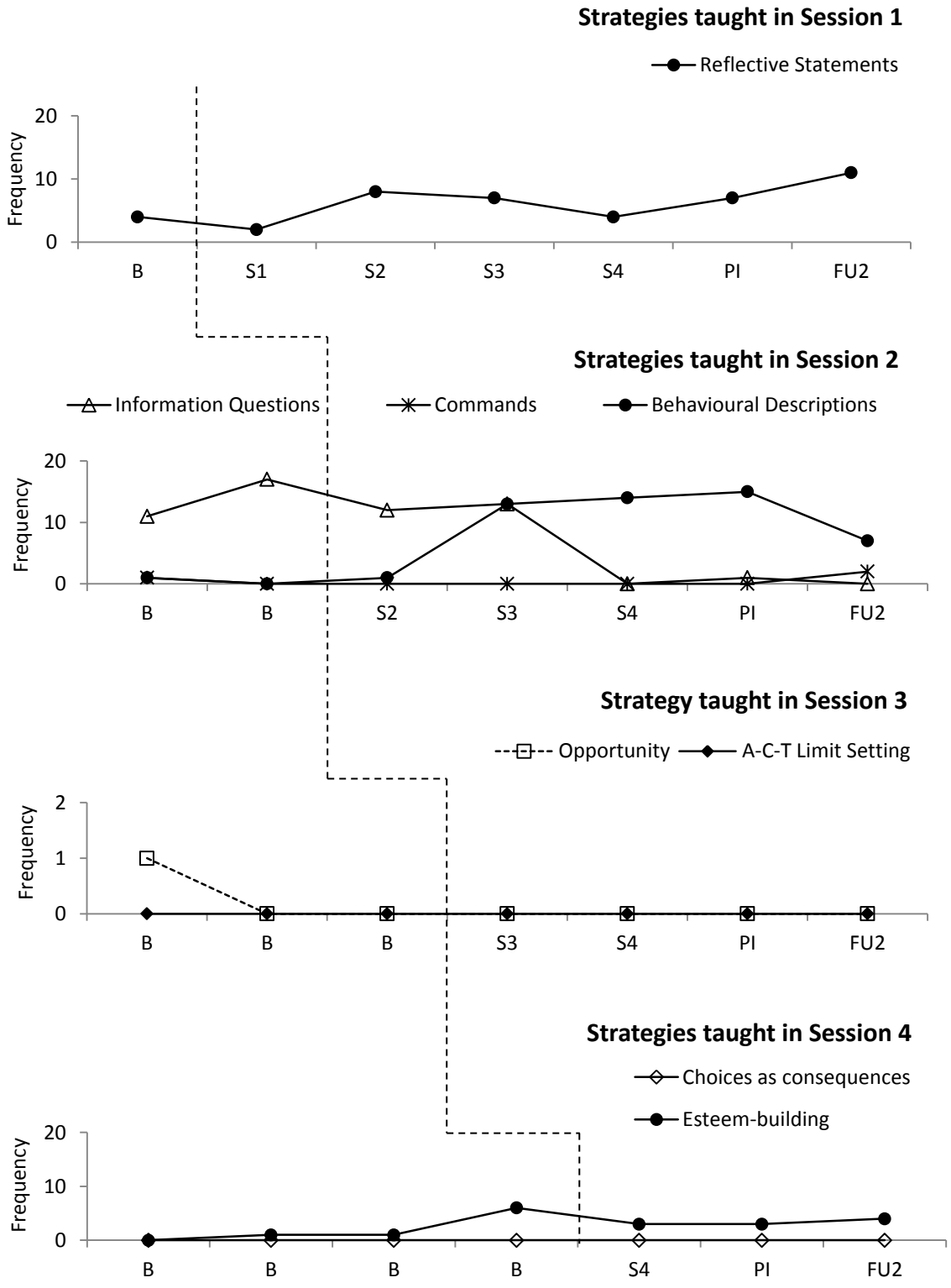


Figure 54. Parent 5's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note.* Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the *A-C-T limit-setting* strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Information questions. At baseline, Parent 5 predominantly asked *information questions* (*n*=11 & 17). There was a decrease in *information questions* (i.e., improvement) in Session 2 (*n*=12) and Session 3 (*n*=13) compared to the second epoch of baseline. This was followed by an improvement in not using *information questions* from Session 4 (*n*=0), which continued until post-intervention (*n*=1) and further at Follow-up 2 (*n*=0).

Commands. At baseline, Parent 5 showed low rates of *commands* (B1; *n*=1; B2=0). This was followed by an improvement in not using *commands* from Session 2 (*n*=0) until post-intervention (*n*=0). However, there was a slight increase in the used of *commands* at Follow-up 2 (*n*=2).

Skills taught in Session 3.

A-C-T limit-setting. Parent 5 did not use *A-C-T limit setting* at baseline, even though there was an opportunity for her to use the strategy. She also did not use *A-C-T- limit setting* in other phases as she had no opportunity to use the strategy as Child 5 did not engage in inappropriate behaviour during the sessions.

Skills taught in Session 4.

Choice-giving as consequences. Parent 5 did not use *choice-giving as consequences* through out the experimental phases as she had no opportunity to use the strategy as Child 5 did not engage in inappropriate behaviour during the sessions.

Esteem-building. Stable, low levels of *esteem-building* responses were noted at early baseline (*n*=0/1), while a steep increase in *esteem-building* responses in the intended direction towards the end of baseline (*n*=6). These were followed by an improvement in the used of *esteem-building* responses in Session 4 (*n*=3) and post-intervention (*n*=3) as well as in Follow-up 2 (*n*=4) compared to the average responses during baseline (*n*=2).

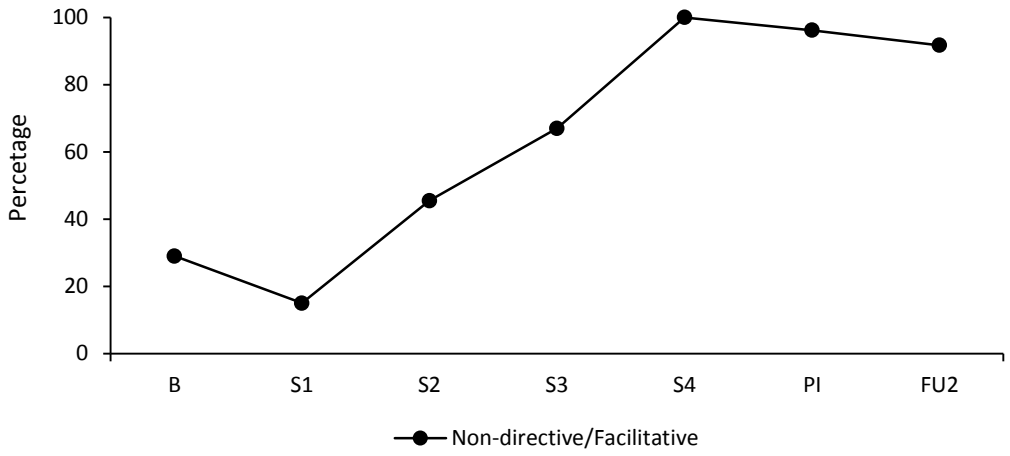


Figure 55. The percentage of non-directive responses of Parent 5 during the 5-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. Parent responses, coded using the DPICS, were grouped to reflect the different degree of parental control in parent responses. Figure 55 shows the percentage of *non-directive* responses of Parent 5 during the 5-minute child-led play sessions across the experimental conditions.

At baseline, Parent 5 used low levels of *non-directive* or *facilitative* responses (*n*=5; 29%), comprising *reflective statements*, *behavioural descriptions* and *esteem-building* responses. With implementation of intervention, Parent 5 gave more *non-directive* responses than she had in baseline, except in Session 1 (*n*=3; 15%). A sharp increasing trend in *non-directive* responses (45%-100%) was noted in Parent 5 within the intervention phase. This was followed by an increase in the use of *non-directive* responses at post-intervention (*n*=22; 96.2%) and Follow-up 2 (*n*=22; 91.7%); high levels of *non-directive* responses were evident in Parent 5.

Observed child responses. Figure 56 displays Child 5's DPICS responses during the 5-minute child-led play sessions across the experimental conditions.

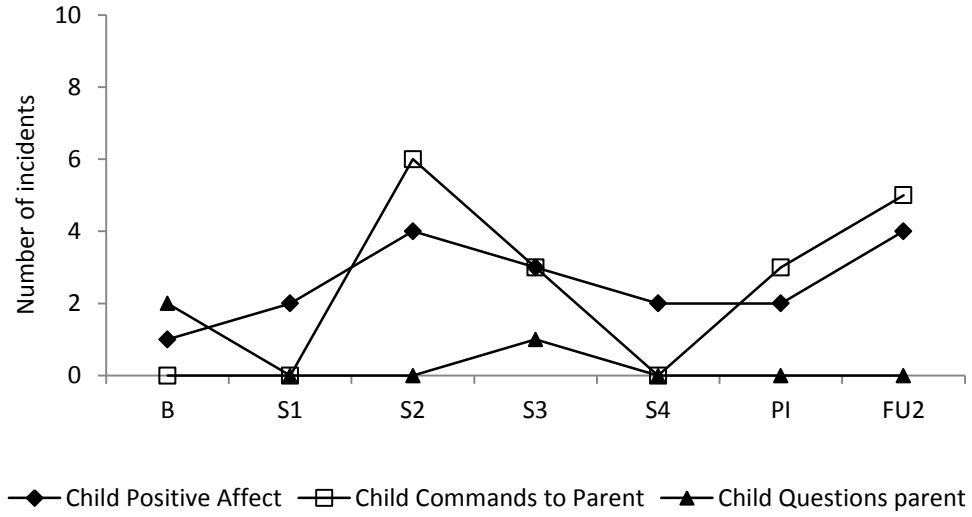


Figure 56. Child 5's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 5 asked few questions (*n*=2), gave no *commands,* and showed low levels of *positive affect* (*n*=1). When intervention occurred, Child 5 approached zero levels of *child questions parent,* with the exception in Session 3 (*n*=1), while he showed more *positive affect* (*n*=2-4) across the intervention period compared to baseline. He also made more *commands* in Session 2 (*n*=6) and Session 3 (*n*=3) than he had in baseline. At post-intervention, Child 5 gave more *commands* (*n*=3) and showed more *positive affect* (*n*=2) compared to baseline, while he did not ask any questions. At Follow-up 2, Child 5 continued to show more *positive affect* (*n*=4) and gave more *commands* (*n*=5) compared to baseline as well as post-intervention. Overall, higher levels of *child positive affect* and *child commands to parent* were evident at Follow-up 2 compared to other experimental conditions, while no *child questions parent* were evident.

Table 21

Scores of Family 5 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	140 (**63**)	125 (58)	132 (**60**)	83 (46)
ECBI-Parent Problem score	17 (**63**)	16 (**62**)	17 (**63**)	2 (43)
PSI-SF (P-CDI) Score	31 (**80**)	28 (72)	--	18 (45)
JPSCS Total Score	38 (54)	38 (54)	--	40 (73)

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parentheses are percentile scores. Percentile scores of 80-84 denote borderline, 85 and above denote clinical significance levels of PSI-SF and are shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- =score is not collected as scheduled. ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline; PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 5's ECBI *Intensity* (T-score = 62) and *Problem* (T-score = 63) scores were at clinically significant levels. Parent 5's *Parent-Child Dsyfunctional Interaction* score of the PSI-SF was in the boerderline range and Child 5's JPSCS score was in the classification of *moderate positive* self-concept. At post-intervention, clinically significant change was evident in the ECBI *Intensity* and PSI-SF *Parent-Child Dsyfunctional Interaction* scores, as both scores reduced to non-clinical levels, while no improvement was reported on child self-concept. At Follow-up 2, positive changes in child and parent functioning were shown on all measures. For instance, parental stress and child problem behaviour (*T-score* =43) and its intensity (*T-score* =46) reduced to non-clinical levels at Follow-up 2. The child rated himself higher in JPSCS, with an increase of 19 percentile, while was one point away from the classification of *high positive* self-concept.

Summary of Family 5. Parent 5 completed the intervention with a high homework completion rate. The mother and child completed all the measures at each phase. Overall,

with implementation of intervention, Parent 5 demonstrated steep improvement in *non-directive* responses. She improved in three of the eight strategies, including *reflective statements, behavioural descriptions* and *esteem-building* responses across phases and one strategy, *information questions,* improved only at Follow-up 2. No improvement was observed in three other strategies, as there were no opportunities to observe this. Child 5 demonstrated more *child positive affect* and gave more *commands,* while he asked fewer *questions*. Clinically significant change was evident in parent perceived child behaviour and parental stress on standardised measures and the child perceived self-concept increased from the classification of *moderate positive* to *high positive*.

Family 6.

Observed parent responses during baseline. Parent 6's DPICS responses during the 5-minute of child-led play sessions across the experimental phases are displayed in Figure 60. There was improvement evident across the phases in six out of seven strategies, including *reflective statements, behavioural descriptions, information questions, command, A-C-T limit-setting* and *esteem-building* responses across phases.

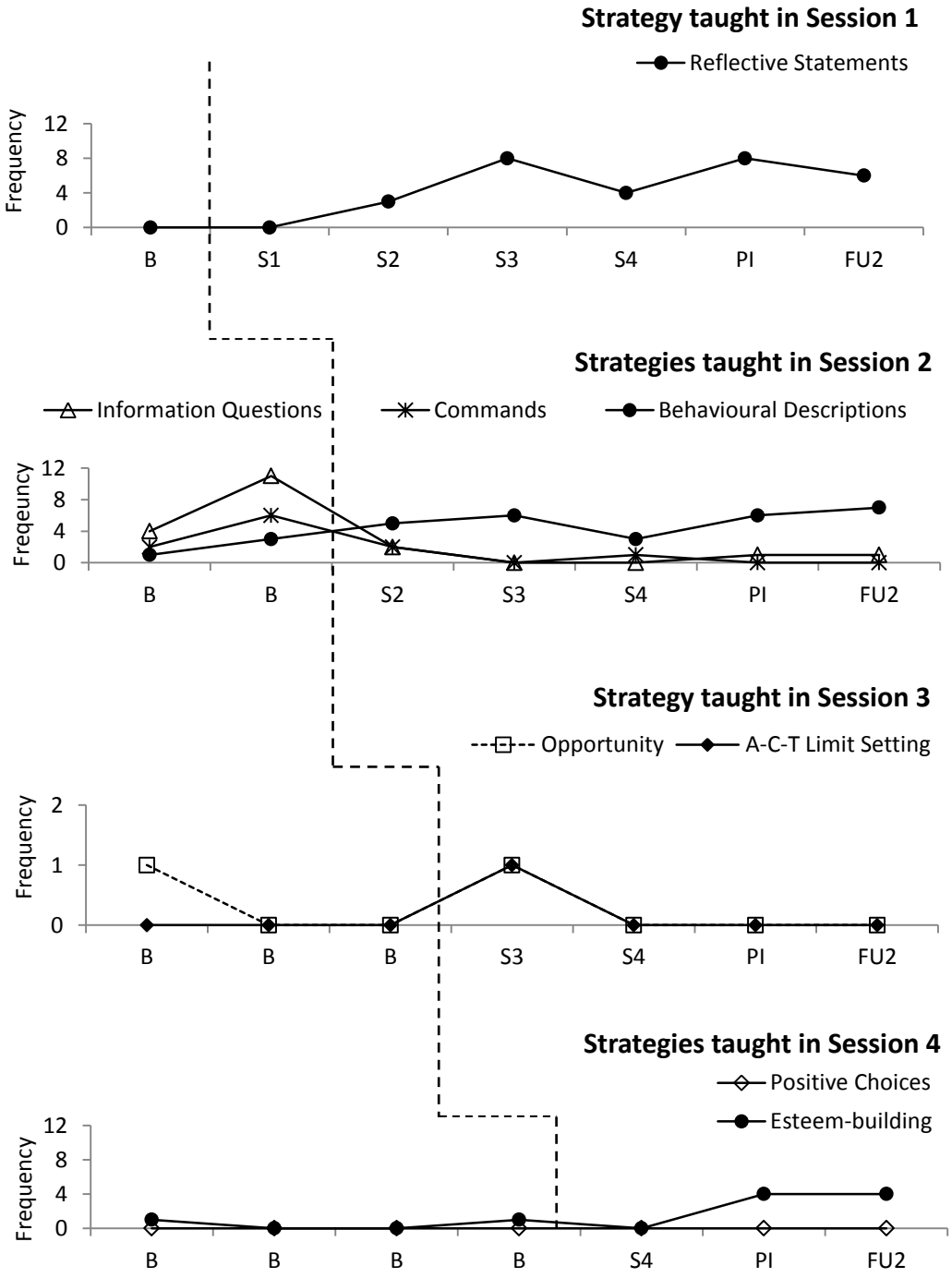


Figure 57. Parent 6's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note.* Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the *A-C-T limit-setting* strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Skill taught in Session 1.

Reflective statements. At baseline, Parent 6 did not use any *reflective statements*. While no changes in the used of *reflective statements* was evidents in Sesion 1 (*n*=0), there has been an increase in the use of *reflective statements* during the intervention (*n*=3-8) since Session 2. This improvement was continued in post-intervention (*n*=8) and Follow-up 2 (*n*=6).

Skills taught in Session 2.

Behavioural descriptions. At baseline, Parent 6 showed low rates of *behavioural descriptions* (*n*=2-3). A slight increment in *behavioural descriptions* in Session 2 (*n*=5) was followed by a sharp increase in Session 3 (*n*=20) and Session 4 (*n*=10) during the intervention. This improvement was maintained at post-intervention (*n*=16) but not at Follow-up 2 (*n*=3).

Information questions. At baseline, Parent 6 predominantly asked information questions; she asked few *information questions* (*n*=4) at the beginning of baseline but more towards the end of baseline (*n*=12). A marked reduction in asking *information questions* (*n*=2) in Session 2 was followed by zero levels of *information questions* in the subsequent sessions during intervention. Parent 6 remained low levels of *information questions* at post-intervention (*n*=1) and Follow-up 2 (*n*=1)

Commands. Parent 6 gave few *commands* at the beginning of baseline (*n*=2) and used more *commands* towards the end of baseline (*n*=6). This was followed by low levels of *commands* throughout the intervention phase (S2, *n*=2; S3, *n*=0; S4, *n*=1). Parent 6 remained zero levels of *commands* at post-intervention and Follow-up 2.

Skill taught in Session 3.

A-C-T limit-setting. Parent 6 used *A-C-T limit setting* when Child 6 attempted to play with a toy car, which was not belong to the special playtimes at Session 3 and Child 6

complied. It was the only opportunity Parent 6 had to implement the strategy during and after the intervention phase.

Skills taught in Session 4.

Esteem-building. Parent 6 showed a stably low levels of *esteem-building* responses at baseline (*n*=0-1). This was followed by a zero levels of *esteem-building* responses at Session 4. Parent 6 showed a marked increase in *esteem-building* responses at post-intervention (*n*=4) and Follow-up 2 (*n*=4).

Positive choices. *Positive choices* were not evident across all phases, which was consistent with the objective of the child-centred play sessions.

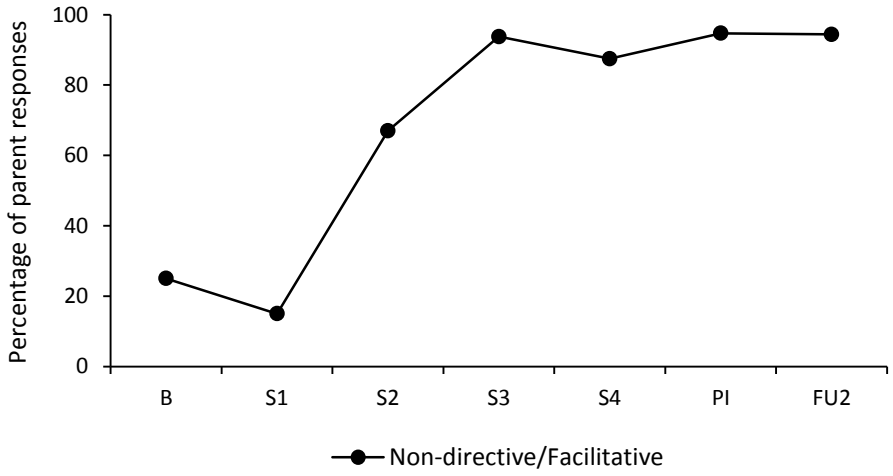


Figure 58. The percentage of non-directive responses of Parent 6 during the 5-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Parent 6 used low levels of *non-directive* or *facilitative* responses (*n*=2; 25%), comprising a *behavioural description* and an *esteem-building* response. With implementation of intervention, Parent 6 gave more *non-directive* responses than she had in baseline, except in Session 1 (*n*=3; 15%). A sharp increasing trend in non-directive

responses (67%-97.75%) was noted in Parent 6 within the intervention phase. This was followed by an increase in the use of non-directive responses at post-intervention (*n*=18; 94.7%) and Follow-up 2 (*n*=17; 94.4%).

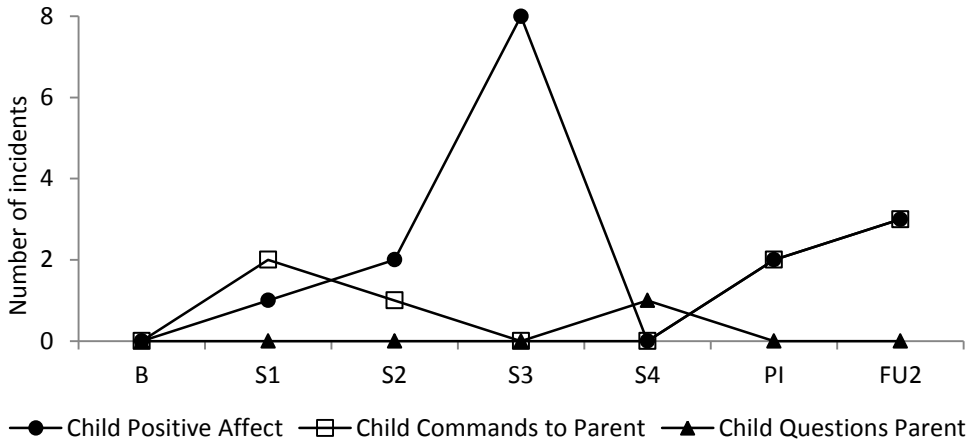


Figure 59. Child 6's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. Figure 59 displays Child 6's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. At baseline, Child 6 did not gave *commands*, did not asked *questions* and did not showed any *positive affect* towards Parent 6. When intervention occurred, an increasing trend in *child positive affect* was evident in the first three intervention sessions (S1, *n*=1; S2, *n*=2; S3, *n*=8) which discontinued at Session 4 (*n*=0). A slight increase in *child commands to parent* during early intervention (S1, *n*=2; S2, *n*=1) but *child commands to parent* were evident in late intervention sessions (*n*=0). No visible change in the number of *child questions parent* was noted within intervention phase compared to baseline. Child 6 showed more *child positive affects* and *child commands to parent* than he had in baseline at post-intervention (*n*=2) and Follow-up 2 (*n*=3) than she had in baseline and remained zero levels of *child questions parent*.

Table 22

Scores of Family 6 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**146** (**64**)	**152** (**66**)	**146** (**64**)	129 (59)
ECBI-Parent Problem score	14 (59)	**15** (**60**)	14 (59)	12 (56)
PSI-SF (P-CDI) Score	29 (76)	31 **(80)**	--	20 (42)
JPSCS Total Score	28 (8)	40 (73)	--	42 (90)

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- =score is not collected as scheduled. ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline, PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 6's ECBI *Intensity* (*T-score* = 64) and Problem (*T-score*=66) scores were at clinically significant levels. Parent 6's *Parent-Child Dysfunctional Interaction* score of the PSI-SF was in the non-clinical range and Child 6's JSPCS score was classified as *very high-risk negative* self-concept. At post-intervention, improvement was evident on Child 6's *Intensity* score, but remainded in clinically significant levels, and JPSCS score which was classified as *moderate positive* self-concept. However, Parent 6's *Parent-Child Dysfunctional Interaction* score deteriorated from the normative range at baseline to the borderline range. At Follow-up 2, clinically significant changes were evident in child and parent functioning on all measures. For instance, Child 6's *Intensity* and *Problem* scores and Parent 6's P-CDI score reduced to non-clinical levels at Follow-up 2 and Child 6 rated himself higher in JPSCS, with an increase of 17 percentile scores, which placed him in the classification of *high positive* self-concept.

Summary of Family 6. Parent 5 completed the intervention with moderate to high homework completion rates, ranging from 64% to 75% for child positive behaviours and 93% for child negative behaviours. The mother and child completed all the measures at each phase. Overall, with implementation of intervention, Parent 6 demonstrated a steep improvement in *non-directive* responses. She improved in six out of seven strategies, including *reflective statements, behavioural descriptions, information questions, commands,* and *A-C-T limit setting* and *esteem-building* responses across phases. Child 6 shown more *child positive affect* towards his mother after the implementation of intervention and shown more *child commands to parents* at early intervention sessions and again at after the intervention concluded. No visible change in the number of *child questions parent* was noted across phases. Clinically significant change was evident in parent perceived child behaviour and parental stress on ECBI and *Parent-Child Dysfunctional Interaction* subscale of PSI-SF, respectively. Likewise, the child perceived self-concept increased from the classification *of very high-risk negative* at baseline to *high positive* at Follow-up 2.

Family 7.

Observed parent responses during baseline. Parent 7's DPICS responses during the 5-minute of child-led play sessions across experimental conditions are displayed in Figure 60. There was improvement evident across the phases in six of the seven strategies, including *reflective statements, behavioural descriptions, information questions, commands* and *esteem-building* responses.

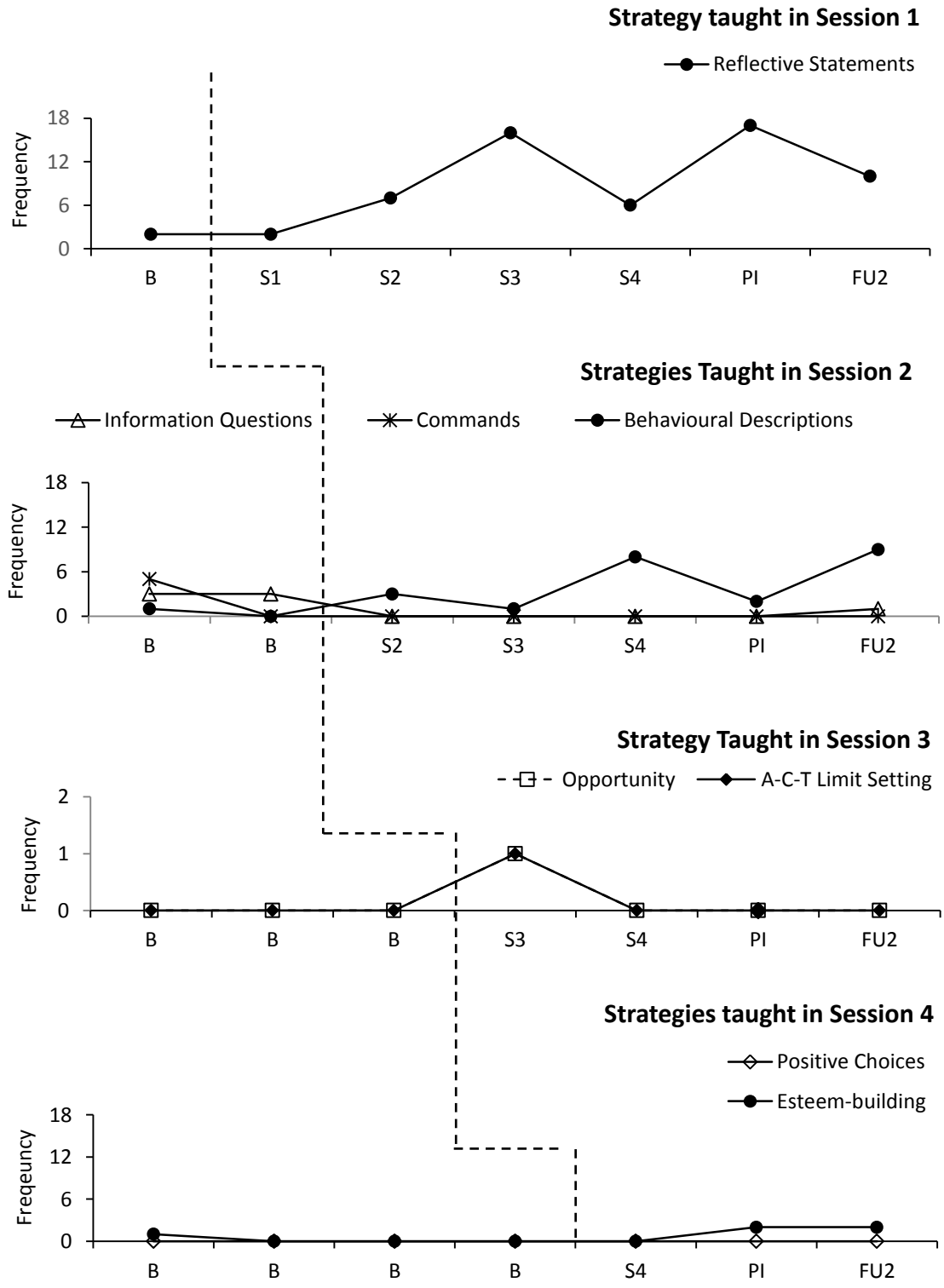


Figure 60. Parent 7's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the *A-C-T limit-setting* strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Skills taught in Session 1.

Reflective statements. Parent 7 made few *reflective statements* (*n*=2) at baseline and there was no change from baseline to Session 1 (*n*=2). This was followed by a sharp increase in *reflective statements* from Session 2 (*n*=7) which continued at post-intervention (*n*=17) and up to Follow-up 2 (*n*=10).

Skills taught in Session 2.

Behavioural descriptions. At Baseline, Parent 7 showed low rates of *behavioural descriptions* (*n*=1 & 0). *Behavioural descriptions* was increased from Session 2 (*n*=3) which continued until post-intervention (*n*=2) and further at Follow-up 2 (*n*=9).

Commands. Parent 7 gave more *commands* in early baseline (*n*=5) but none toward the end of baseline. She remained zero levels of *commands* during and after the intervention.

Information questions. At baseline, Parent 7 asked few *information questions* (*n*=3). This was followed by zero levels of *information questions* during and after the intervention, except in Follow-up 2 (*n*=1).

Skills taught in Session 3.

A-C-T limit-setting. Parent 7 used *A-C-T limit setting* in Session 3 when Child 7 ran out of the play session area, which was carried out at the participant's home, and Child 7 returned to the play area. It was the only opportunity Parent 7 had to implement the strategy during the child-led play sessions within the intervention phase.

Skills taught in Session 4.

Esteem-building. Parent 7 did remained low to zero levels of *esteem-building* responses during baseline. There was no change from baseline to Session 4 (*n*=0). This was followed by an increase at post-intervention (*n*=2) and Follow-up 2 (*n*=2).

Positive choices. Parent 7 remainded zero levels of *positive choices* throughout the experimental phases.

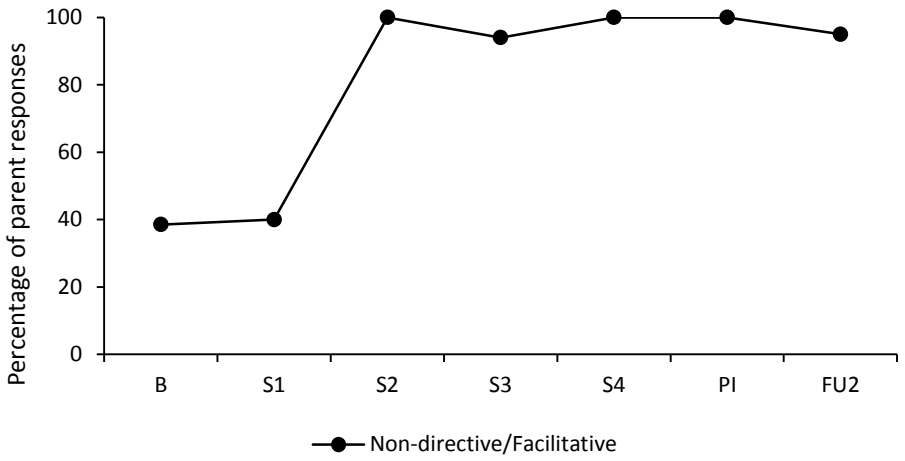


Figure 61. The percentage of non-directive responses of Parent 7 during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. Parent responses, coded using the DPICS, were grouped to reflect the different degree of parental control in parent responses. Figure 61 shows the percentage of *non-directive* responses of Parent 7 during the 5-minute child-led play sessions across the experimental conditions. At baseline, Parent 7 used low levels of *non-directive* or *facilitative* responses (*n*=5, 38.5%), comprising *reflective statements*, a *behavioural description* and an *esteem-building* response. With implementation of intervention, Parent 7 increased markedly in *non-directive* responses than she had in baseline from Session 2 (*n*=10, 100%), which was continued at post-intervention (*n*=21, 100%) and Follow-up 2 (*n*=21 or 95%).

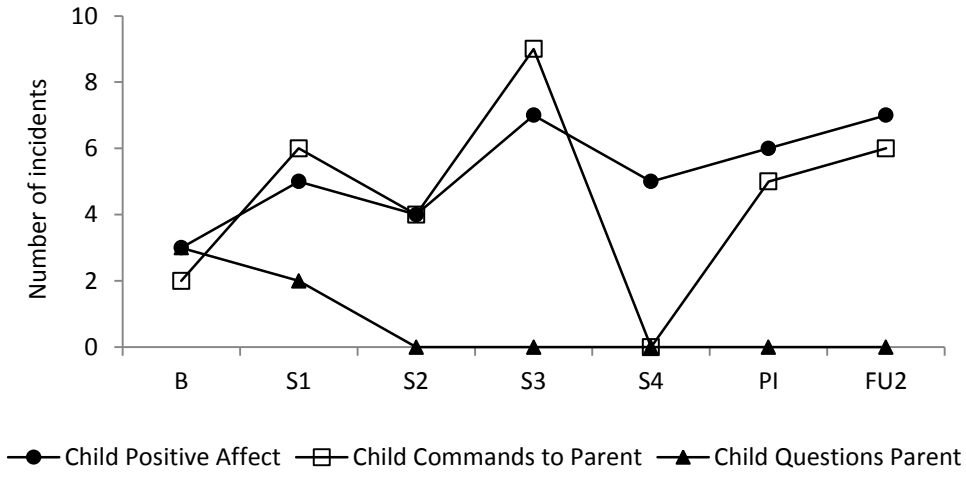


Figure 62. Child 7's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. Figure 62 displays Child 7's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. This section presents data pertaining to corresponding changes in children's responses during the parent child play sessions. At baseline, Child 7 showed few *child positive affect* (*n*=3), few *child commands to parent* (*n*=2) and few *child questions parent* (*n*=3). When intervention occurred, Child 7 showed more *child positive affect* (*n*=4-7) and more *child commands to parent* (*n*=4-9), except in Session 4 (*n*=0), while she engaged in fewer c*hild questions parent* (*n*=0-2) than she had in baseline. Child 7 showed more *child positive affect* and *child commands parent* at post-intervention (*n*= 6; *n*=5) and Follow-up 2 (*n*=7; *n*=6) than he had in baseline, while he did not ask any *questions*. Overall, an increasing trend in *child positive affect* and *child commands to parent*, while a decreasing trend in *child questions parent* were observed during and after the implementation of the intervention.

Table 23

Scores of Family 7 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**136** (**61**)	111 (54)	90 (48)	78 (45)
ECBI-Parent Problem score	**16** (**62**)	6 (49)	5 (47)	2 (43)
PSI-SF (P-CDI) Score	28 (72)	27 (70)	--	26 (66)
JPSCS Total Score	40 (73)	42 (90)	--	42 (90)

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI-SF and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- =score is not collected as scheduled. ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent-Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline; PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 7's ECBI *Intensity* (*T-score* = 61) and *Problem* (*T-score* = 62) scales were at clinical levels. Parent 7's *Parent-Child Dysfunctional Interaction* of score the PSI-SF was in normative range and Child 7's JPSCS score was classified as *moderate positive* self-concept. At post-intervention, improvement was reported on all measures. For instance, Child 7's *Intensity* score (*T-score* = 54) reduced to non-clinical levels and the child's score on the JPSCS increased and was classified as *high positive* self-concept. Parent 7's *Parent-Child Dysfunctional Interaction* score reduced slightly and remained in non-clinical levels. The improvement in all measures was either maintained or further improved at follow-ups and remainded in non-clinical levels and in the classification of *high positive* self-concept.

Summary of Family 7. Parent 7 (mother) completed the intervention with high homework completion rates. Parent 7 improved in six of the seven strategies, including *reflective statements, behavioural descriptions, information questions, commands, A-C-T limit-setting* and *esteem-building* responses across phases. Overall, a marked improvement in *non-directive* response was evident in Parent 7 after Session 1. After the implementation of intervention, Child 7 shown more *positive affect*, gave more *commands* and asked fewer *questions* to her parent. Clinically significant change was evident in parent perceived child behaviour from clinically significant levels at baseline to non-clinical levels after the intervention. The child's perceived self-concept increased from the classification of *moderate positive* at baseline to *high positive* after the intervention. Parent 7 reported reductions in parental stress after the intervention and remained in non-clinical levels.

Family 8.

Observed parent responses during baseline. Parent 8's DPICS responses across the experimental phases are displayed in Figure 63. There was improvement evident across the phases in six out of the seven strategies, including *reflective statements, behavioural descriptions, information questions, commands* and *esteem-building* responses.

Skills taught in Session 1.

Reflective statements. At Baseline, Parent 8 did not use any *reflective statements*. This was followed by an immediate increase in *reflective statements* throughout the intervention phase (n=2-3), which continued to increase at post-intervention (n=5) and Follow-up 2 (n=7).

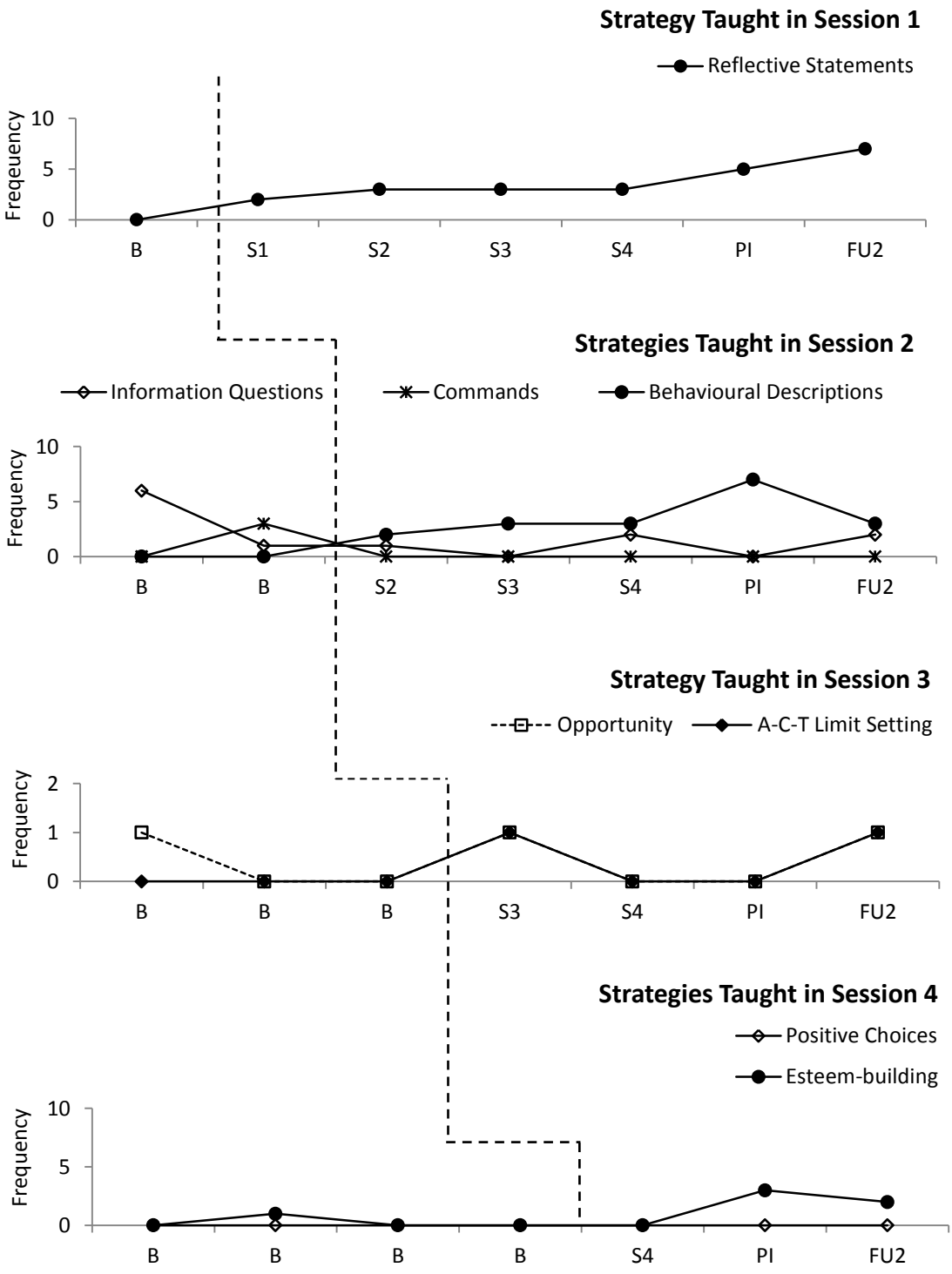


Figure 63. Parent 8's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the A-C-T limit-setting strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=follow-up 2.

Skills taught in Session 2.

Behavioural descriptions. At baseline, Parent 8 showed zero levels of *behavioural descriptions*. This was followed by an immediate increase in *behavioural descriptions* throughout the intervention phase (*n*=2-3), which continued to increase at post-intervention (*n*=7) and remained improved at Follow-up 2 (*n*=3).

Information question. Parent 8 predominantly asked *information questions* during early baseline (*n*=6) and reduced marked towards the end of baseline (*n*=1). There was followed by low levels of *information questions* used by Parent 8 throughout the intervention (*n*=0-2) and remainded stable at post-intervention (*n*=0) and Follow-up 2 (*n*=2).

Commands. At baseline, Parent 8 showed zero to low rates of *commands* (*n*=0-3). Parent 8 maintained zero levels of *commands* during and after the intervention concluded.

Skills taught in Session 3.

A-C-T limit-setting. Parent 8 used *A-C-T limit setting* when Child 8 intended to get out from the playroom during the child-led play, in Sesion 3, and the child complied and remainded in the playroom. It was the only opportunity Parent 8 had to implement the strategy during the child-led play sessions within the intervention phase.

Skills taught in Session 4.

Esteem-building. Parent 8 maintained zero to low levels of *esteem-building* responses during baseline (*n*=0-1). There was no change from baseline to Session 4 (*n*=0). This was followed by an increase in *esteem-building* responses at post-intervention (*n*=3) and Follow-up (*n*=2).

Positive choices. Parent 8 did not demonstrate the use of *positive choices* throughout the study, which was consistent with the intended direction of the intervention.

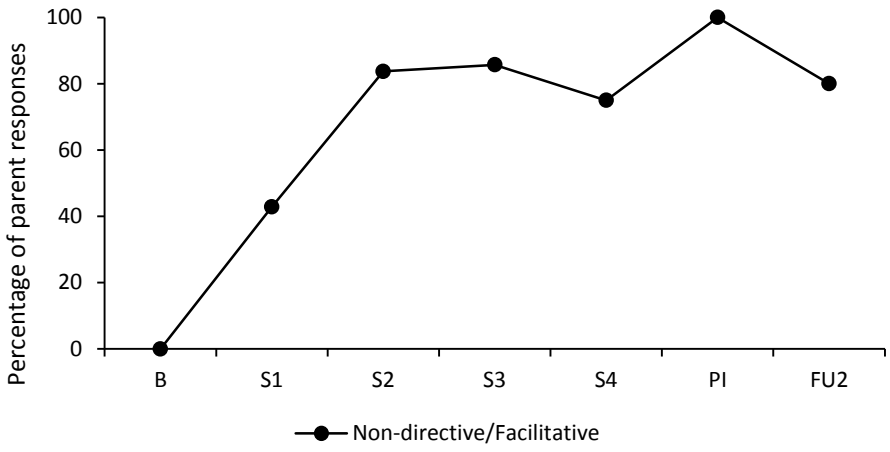


Figure 64. The percentage of non-directive responses of Parent 8 during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. Parent 8's responses, coded using the DPICS, were grouped to reflect the different degree of parental control in parent responses. Figure 64 shows the percentage of non-directive responses of Parent 8 during the 5-minute child-led play sessions across the experimental conditions. At baseline, Parent 8 demonstrated zero levels of *non-directive* or *facilitative* responses. With implementation of intervention, Parent 8 demonstrated a sharp increasing trend in using *non-directive* during the intervention (S1=42.9%; S4=75%). This was followed by a futhrer increase in *non-directive* responses at post-intervention (*n*=15 or 100%) and Follow-up 2 (*n*=12 or 80%).

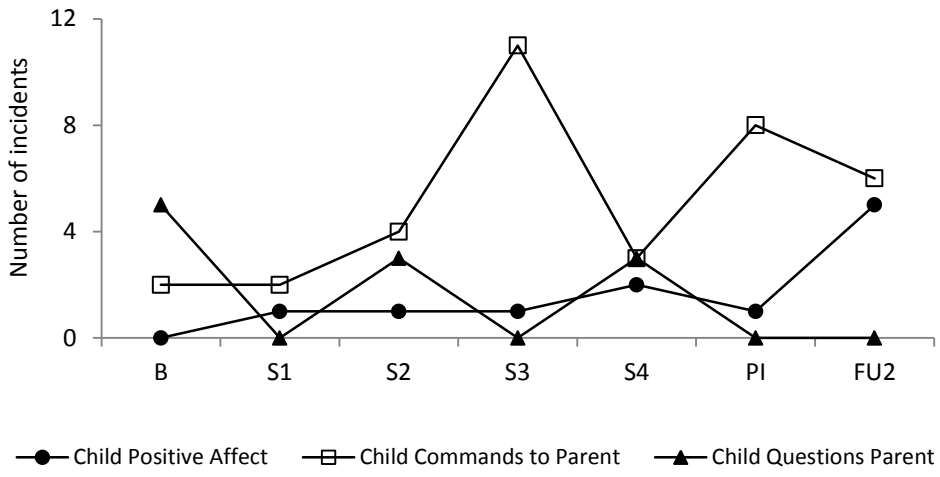


Figure 65. Child 8's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. At baseline, Child 8 asked few *questions* (*n*=5), gave few *commands* (*n*=2) but did not show any *child positive affect*. When intervention occurred, Child 8 showed more *positive affect* (*n*=1-2) and gave more *commands* (*n*=2-11), while he asked fewer *questions* (*n*=0-3) than he had in baseline. At post-intervention, Child 8 showed more *positive affect* (*n*=1), gave more *commands* (*n*=8) than he had in baseline and he did not ask any *questions* (*n*=0). The increase in *child positive affect* (*n*=5) and *child commands to parent* (*n*=5), while the reduction in *child questions parent* (*n*=0) were remained at Follow-up 2.

Table 24

Scores of Family 8 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**205** (**81**)	**139** (**62**)	108 (53)	107 (53)
ECBI-Parent Problem score	**34** (**85**)	**27** (**76**)	6 (49)	9 (52)
PSI-SF (P-CDI) Score	34 (**86**)	29 (76)	--	27 (70)
JPSCS Total Score	12 (≤1)	15 (≤1)	--	32 (4)

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI-SF and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- =score is not collected as scheduled. ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline; PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 8's ECBI *Intensity* (*T-score* = 81) and *Problem* (*T-score* = 85) scores were in clinically significant levels. Parent 8's *Parent-Child Dysfunctional Interaction* subscale score of the PSI-SF was in clinically significant levels and Child 8's score on the JPSCS was classified as *very high-risk negative* self-concept. At post-intervention, clinical significant change was evident in the Parent's P-CDI ratings and the child's *Intensity* score (*T-score* = 62) reduced markedly, however, it still remained at clinical levels; while the child's JPSCS classification remained unchanged as in baseline. Clinical significant change was evident in ECBI scores at follow-ups and *Parent-Child Dysfunctional Interaction* subscale score of PSI-SF at post-intervention and Follow-up 2, both ratings were in normative ranges, while the child's JPSCS score increased markedly and moved to the classification of *poor* self-concept (i.e., improvement).

Summary of Family 8. Parent 8 completed the intervention with a high homework completion rate of 81%. She improved in six out of seven strategies, including *reflective statements, behavioural descriptions, information questions, commands, A-C-T limit-setting* and *esteem-building* responses across phases. Overall, a substantial improvement in *non-directive* response was evident in Parent 8. After the implementation of intervention, Child 8 shown more *positive affect*, gave more *commands* to his mother and asked fewer *questions*. Clinically significant changes were evident in parent perceived child behaviour and parenting stress on ECBI and the *Parent-Child Dysfunctional Interaction* subscale of PSI-SF, respectively, after the intervention concluded. Similarly, a marked increase in the child's perceived self-concept was evident at Follow-up 2.

Family 9.

Observed parent responses during baseline. Parent 9's DPICS responses across the phases are displayed in Figure 66. Parent 9 showed intended improvement of the intervention, such as reductions in *information questions* and *commands*, after attending an intervention session. Parent 9 declined her participation after attended Session 2.

Skills taught in Session 1.

Reflective statements. At baseline Parent 9 gave few *reflective statements*. There was no change from baseline to Session 1 (n=2).

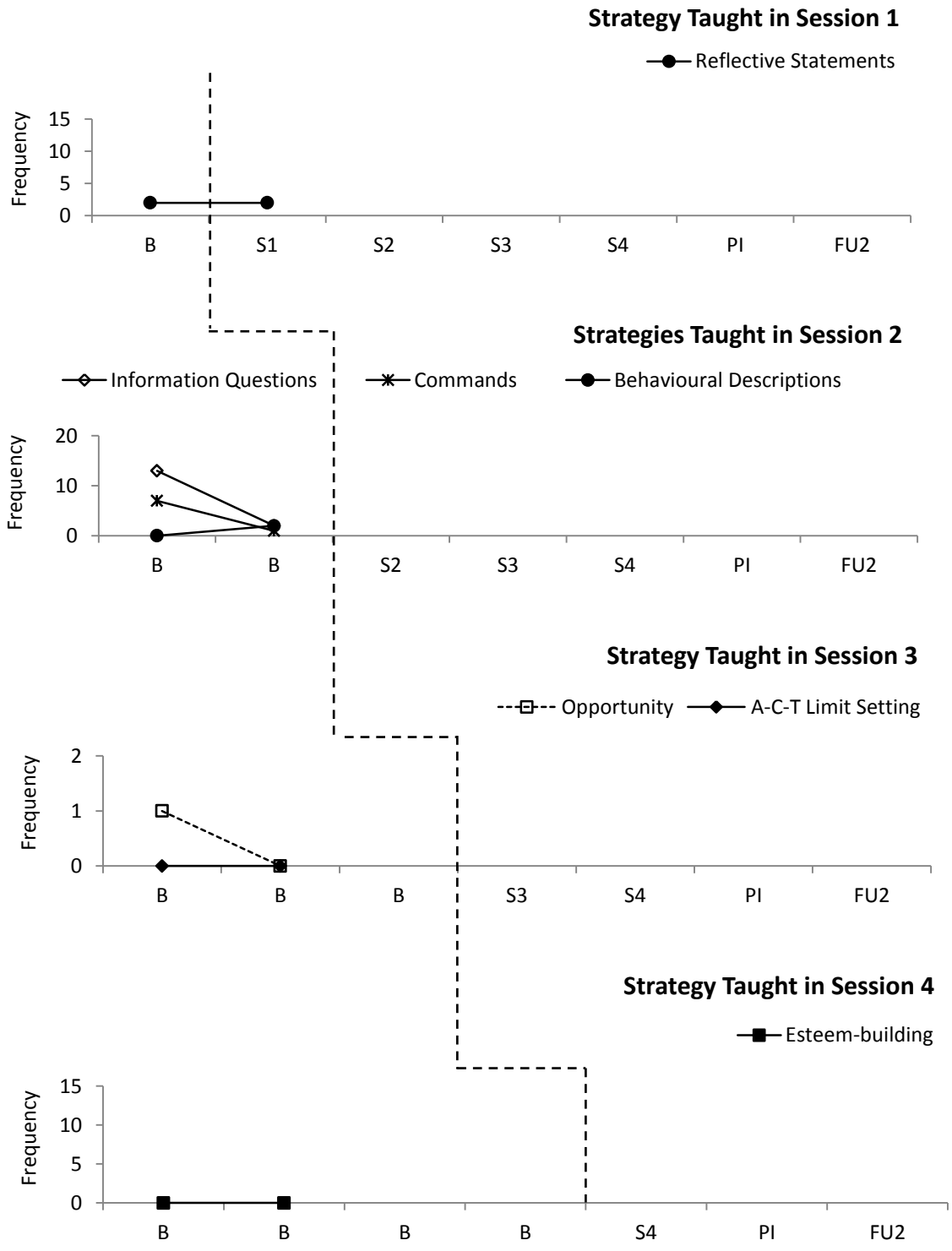


Figure 66. Parent 9's DPICS responses during the 5-minute child-led play sessions at baseline and post Session 1. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the A-C-T limit-setting strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Skills taught in Session 2.

Behavioural descriptions. At baseline, Parent 8 did not use any *behavioural descriptions*. This was followed by an increase in Session 1 (*n*=2).

Information questions. At baseline, Parent 9 predominantly asked *information questions* (*n*=13). This was followed by a marked reduction in *information questions* in Session 1 (*n*=2).

Commands (Session 2). At baseline, Parent 9 predominantly gave *commands* (*n*=7). This was followed by a sharp reduction in *commands* in Session 1 (*n*=1).

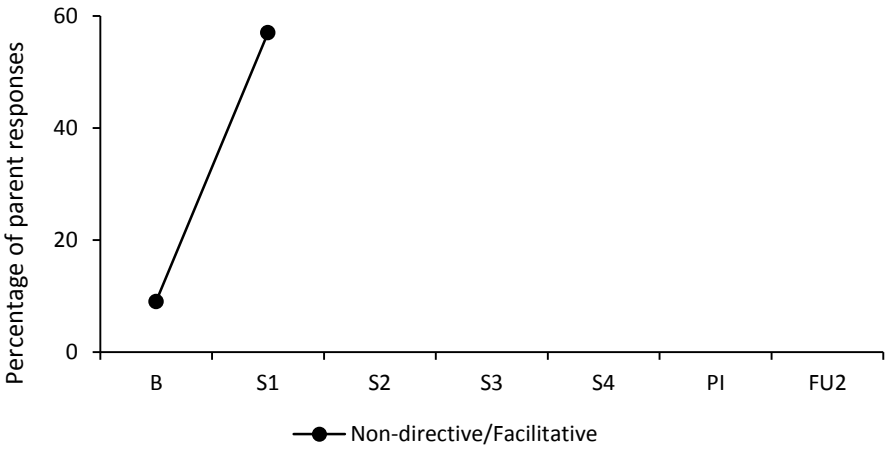


Figure 67. The percentage of non-directive responses of Parent 9 during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. At baseline (Figure 67), Parent 9 demonstrated low levels of *non-directive* responses (*n*=2, 9%). Parent 9 made a sharp increase *non-directive* responses (*n*=4; 57%) in Session 1.

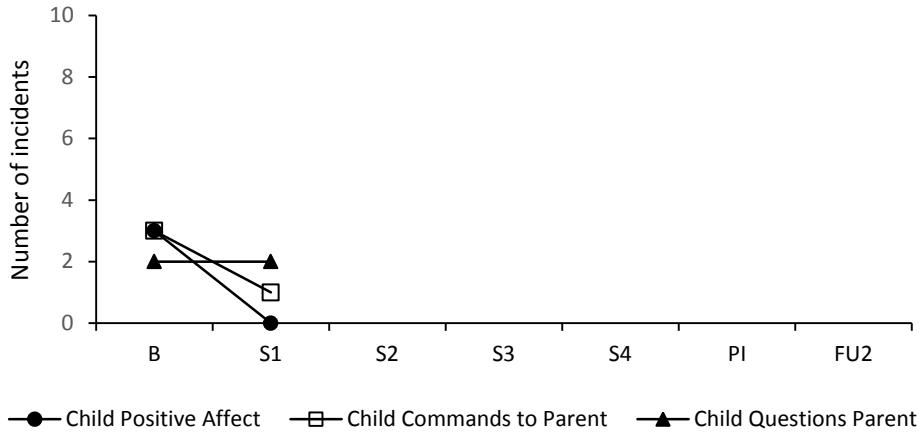


Figure 68. Child 9's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. At baseline, Child 9 showed few *positive affect* (*n*=3), gave few *commands* (*n*=3) to his mother and asked few *questions* (*n*=2). In Session 1, Child 9 reduced in *child commandsto parent* (*n*=1) and *child positive affect* (*n*=0), while no changes was evident in *child questions parent* compared to baseline.

Table 25

Scores of Family 9 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**203 (81)**	X	X	X
ECBI-Parent Problem score	**34 (85)**	X	X	X
PSI-SF (P-CDI) Score	25 (62)	X	--	X
JPSCS Total Score	38 (54)	X	--	X

Note. Raw scores are presented. ECBI data in parentheses are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parentheses are percentile scores. Percentile scores of 80-84 denote borderline, 85 and above denote clinical significance levels of PSI-SF and are shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. --=score is not collected as scheduled; ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; X=data were not available as the family dropped out from the study; B=Baseline; PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 9's ECBI *Intensity* (*T-score*= 80) and *Problem* (*T-score*= 85) scores were at clinically significant levels. Parent 9's *Parent-Child Dysfunctional Interaction* score of PSI-SF was in the normative range. Child 9's JPSCS score was classified as *moderate positive* self-concept.

Summary of Family 9. Parent 9 participated but did not complete the intervention. She attended two intervention sessions. The mother and daughter participated in two video observations, one at baseline and another after Session 1. At baseline, Parent 9 rated her daughter behaviour at clinical significant levels, while she rated her own stress related to *Parent-Child Dysfunctional Interaction* in the normative range. Child 9 rated her self-concept in the classification of *moderate positive*. The mother only recorded the child's behaviours during baseline. The mother did not improve in *reflective statements* after it was taught, however she made a noticeable improvement in *non-directive* response at post

Session 1, by a great reduction in *information questions* and *commands*. Child 9 demonstrated fewer *child positive affect* and fewer *child commands to parent* at Session 1, while no changes in *child questions parent* was evident.

Family 10.

***Observed parent responses across phases*.** The parent's DPICS responses across the phases are displayed in Figure 69. There was improvement evident across the phases in six out of seven strategies, including *reflective statements, behavioural descriptions, information questions, commands, A-C-T limit-setting, choice-giving as consequences* and *esteem-building* responses.

Skills taught in Session 1.

Reflective statements. At baseline, Parent 10 demonstrated high levels of *reflective statements* (*n*=8). This was followed by a reduction in *reflective statements* (*n*=6) during the intervention, with the exception in Session 3 (*n*=16). Increment in *reflective statements* was evident at post-intervention (*n*=17) and Follow-up 2 (*n*=11).

Skills taught in Session 2.

Behavioural descriptions. At baseline, Parent 10 showed low rates of *behavioural descriptions* (*n*=2-3). This was followed by an immediate improvement in the use of *behavioural descriptions* from Session 2 (*n*=5) which continued until post-intervention (*n*=16) but was not remained at Follow-up 2 (*n*=3).

Information questions. Parent 10 predominantly asked *information questions* (*n*=8) in early baseline but reduced it (*n*=2) towards the end of baseline. This was followed by a reduction in *information questions* in the following session (S2; *n*=1) before it was omitted from Session 3 through Follow-up 2 (*n*=0).

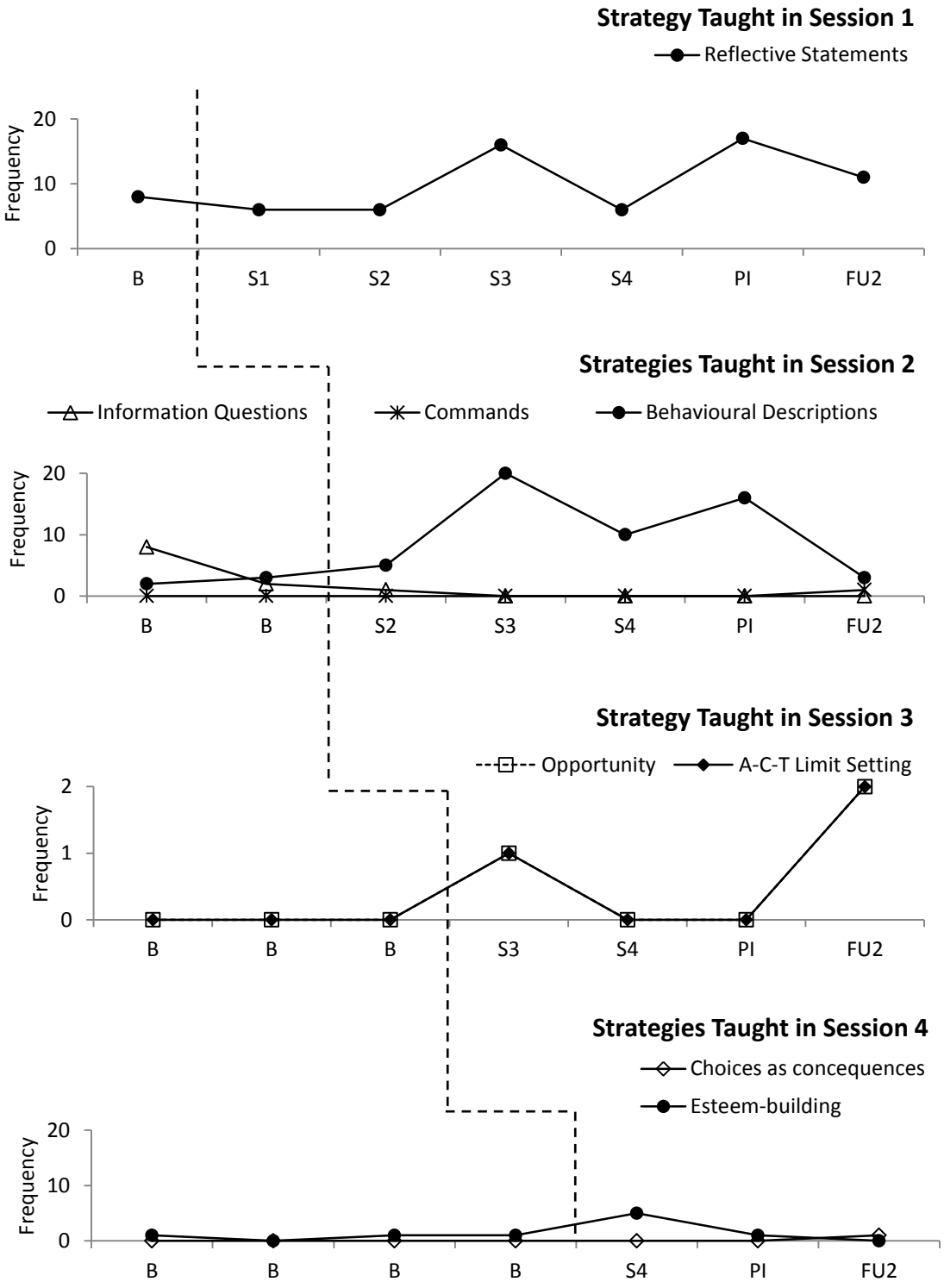


Figure 69. Parent 10's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the A-C-T limit-setting strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Commands. At baseline, Parent 10 did not give any *commands*. She remained zero levels of *commands* during intervention phase, which continued until post-intervention (*n*=0) but not at Follow-up 2 (*n*=1).

Skills taught in Session 3.

A-C-T limit-setting. In Session 3, Parent 10 used *A-C-T limit setting* when Child 10 intended to hit her with a screwdriver; Child 10 responded to the limit and continued playing with tools. At Follow-up 2, Parent 10 had two opportunities to implement the strategy and she did accordingly.

Skills taught in Session 4.

Esteem-building. At baseline, Parent 10 demonstrated low levels of *esteem-building* responses (*n*=0/1). This was followed by an immediate increase in *esteem-building* in Session 4 (*n*=5), which was not retain at post-intervention (*n*=1) and Follow-up 2 (*n*=0).

Choice-giving as consequences. Parent 10 had an opportunity to implement the strategy and she did accordingly.

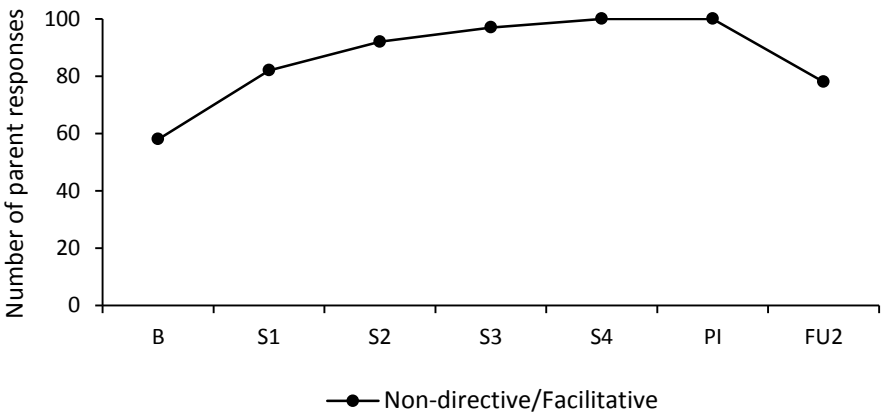


Figure 70. The percentage of non-directive responses of Parent 10 during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. At baseline, Parent 10 demonstrated moderate levels of *non-directive* or *facilitative* responses (*n*=11; 58%), comprising *reflective statements*, *behavioural descriptions*, and *esteem-building* responses. With implementation of intervention, Parent 10 demonstrated a sharp increasing trend in *non-directive* responses (S1=82%; S4=100%). This improvement was remained stable at post-intervention (*n*=34; 96.2%) and Follow-up 2 (*n*=14; 78%).

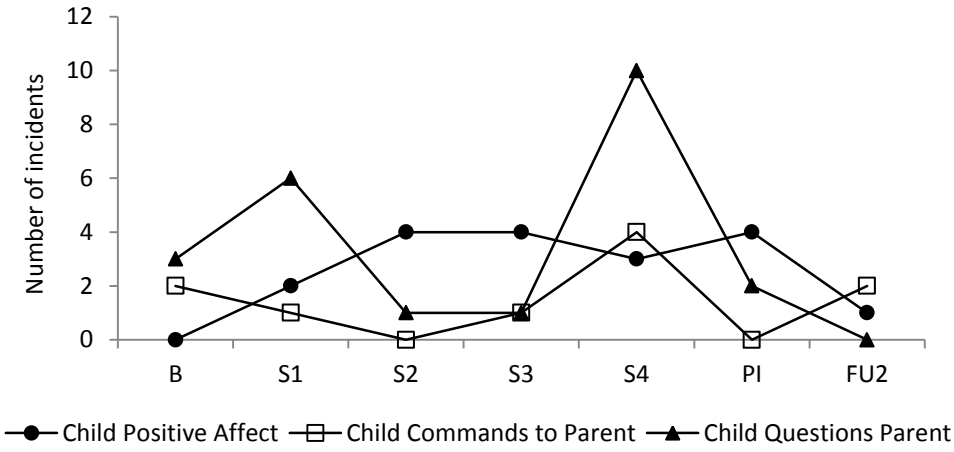


Figure 71. Child 10's DPICS responses during the 5-minute child-led play sessisons across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. At baseline, Child 10 gave few *commands* (*n*=2) and asked few *questions* (*n*=3), while *child positive affect* was not evident. When intervention occurred, Child 10 showed more *child positive affect* (*n*=2-4) and gave fewer *commands* (*n*=0-1) than he had in baseline, with the expection in Session 4 (*n*=6). The number of questions asked by Child 10 was highly variable across the intervention phase. A marked increased in *child questions parent* was noted in early and late intervention (S1, *n*=6; S4, *n*=10), while a decrease in *child questions parent* was evident in mid-intervention sessions (S2, *n*=1; S3,

n=1). At post-intervention, Child 10 showed more *child positive affect* (*n*=4) and showed fewer *child questions parent* (*n*=2) than he had in baseline, while he did not gave any *commands* to his mother. At Follow-up 2, Child 10 demonstrated more *child positive affect* (*n*=1), showed fewer *child questions parent* (*n*=0) than he had in baseline, while no change in *child commands to parent* (*n*=2) was evident.

Table 26

Scores of Family 10 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**142** (**63**)	82 (46)	65 (41)	126 (58)
ECBI-Parent Problem score	**16** (**62**)	0 (41)	0 (41)	5 (47)
PSI-SF (P-CDI) Score	24 (58)	17 (28)	--	17 (28)
JPSCS Total Score	42 (90)	38 (54)	--	40 (73)

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI-SF and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- = score is not collected as scheduled; ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form;* P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline, PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 10's ECBI *Intensity* (*T-score* = 63) and *Problem* (*T-score* = 62) scores were at clinically significant levels. Parent 10's *Parent-Child Dysfunctional Interaction* score of the PSI-SF was in the normative range. Child 10's JPSCS score was classified as *high positive* self-concept at post-intervention, clinically significant change was evident in child 10's *Intensity* and *Problem* scores, both scores reduced to nonclinically significant levels, which were remained at Follow-up 1 and 2. Parent 10's *Parent-Child Dysfunctional Interaction* score reduced and remained in the

normative range at post-intervention and Follow-up 2. Child 10's JPSCS score decreased from the classification of *high positive* at baseline to *moderate positive* self-concept at post-intervention and Follow-up 2.

***Summary of Family* 10.** Parent 10 completed the intervention with a high homework completion rate of 76%. She improved in five of the seven strategies, including *reflective statements, behavioural descriptions, information questions, A-C-T limit setting* and *esteem-building* responses during intervention phase. No improvement in two other strategies, as there were any opportunities to observe this. Overall, Parent 10 made a considerable improvement in *non-directive* responses. Child 10 showed more *child positive affect* after the implementation of intervention, the number of *child commands to parent* given and *child questions parent* used by Child 10 was fluctuated across the experimental period. Clinically significant change was evident in parent perceived child behaviour. A reduction was evident in parent's perceived parenting stress related to parent-child dysfunctional interaction and in child's perceived positive self-concept, but remained in the *positive* range of self-concept.

Family 11.

Observed parent responses across phases.

Skills taught in Session 1.

Reflective statements. At baseline, Parent 11 made few *reflective statements* (*n*=2). This was followed by an increasing trend in *reflective statements* was evident during the intervention (S1, *n*=8; S4, *n*=17). This improvement was remained at post-intervention (*n*=16).

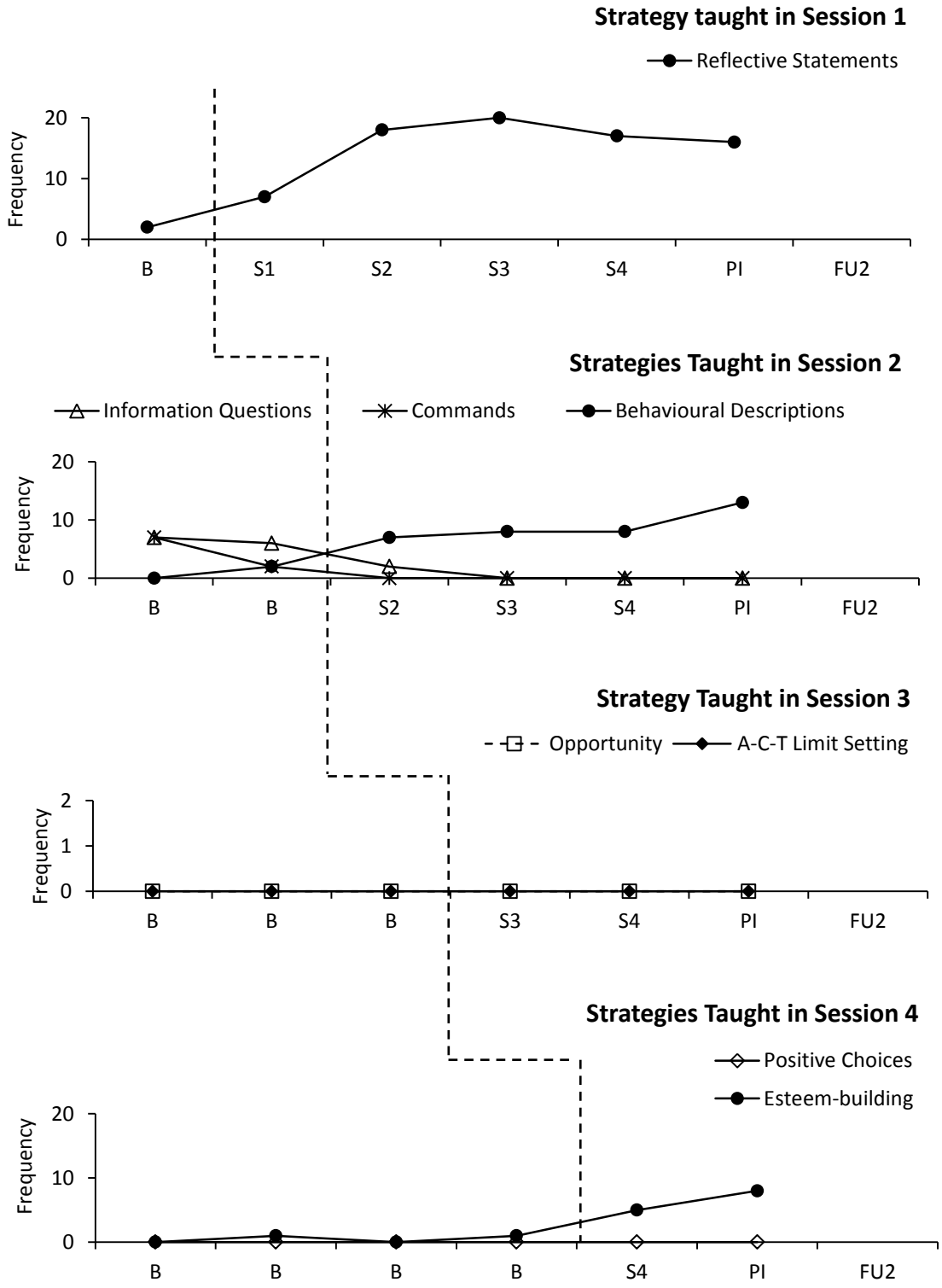


Figure 72. Parent 11's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the A-C-T limit-setting strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Skills taught in Session 2.

Behavioural descriptions. At Baseline, Parent 10 showed low rates of behavioural descriptons (n=0-2). This was followed by an immediate increase in behavioural descriptions during the intervention (S2, n=7; S3, n=8; S4, n=8) and a further increase at post-intervention (n=13).

Information questions. At baseline, Parent 11 predominantly asked *information questions* (*n*=6-7). A sharp decrease in *information questions* in Session 2 (*n*=2) was followed by zero levels of *information questions* from Session 3 until post-intervention.

Commands. Parent 11 predominantly gave *commands* during early baseline (*n*=7) and then reduced it towards the end of baseline (*n*=2). Parent 11 showed immediacte reduction in *commands* to zero levels from Session 2 (*n*=0) until post-intervention (*n*=0).

Skills taught in Session 3.

A-C-T limit-setting. Parent 11 had no opportunity to demonstrate the strategy as Child 11 did not engage in any inappropriate behaviours.

Skills taught in Session 4.

Choice-giving as consequences. Parent 11 did not have any opportunities to use the strategy as Child 11 did not engage in any inappropriate behaviour.

Esteem-building. At baseline, Parent 11 remained low levels of *esteem-building* responses (*n*=0-1). This was followed by an immediate increase in *esteem-building* responses in Session 4 (*n*=5) which continued to increase at post-intervention (*n*=8).

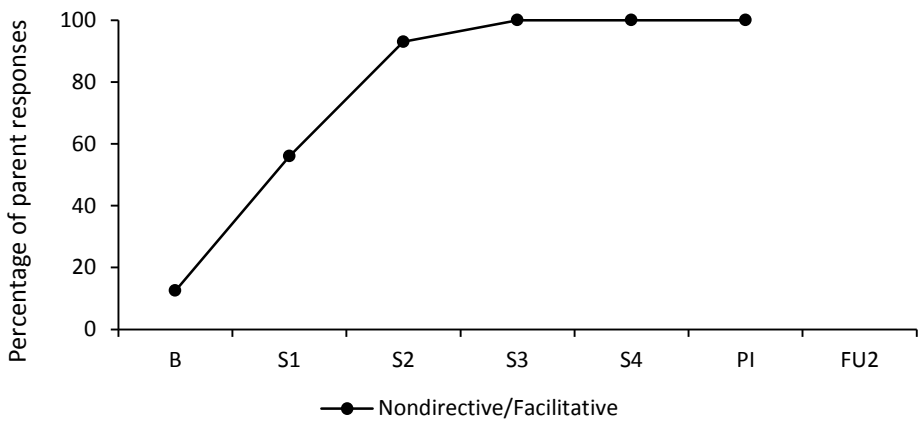


Figure 73. The percentage of non-directive responses of Parent 11 during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Nondirective parent responses. At baseline, Parent 11 demonstrated low levels of *non-directive* responses (*n*=2; 12.5%). When intervention occurred, Parent 11 demonstrated a sharp increasing trend in *non-directive* responses from Session 1 (56%) until post-intervention (100%).

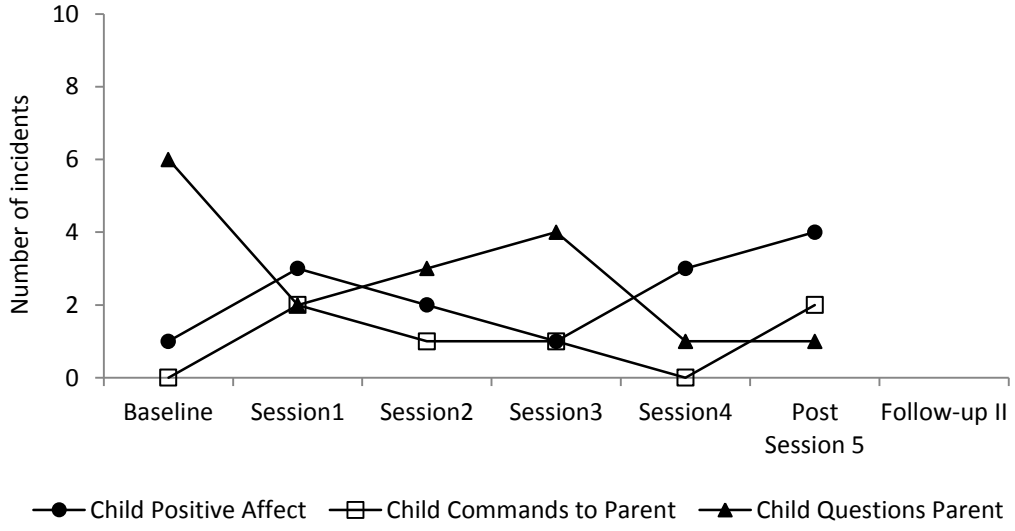


Figure 74. Child 11's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. At baseline, Child 11 mainly asked *questions* (*n*=6), demonstrated *positive affect* once (*n*=1) and did not gave any *commands* to his mother. When intervention occurred, Child 11 demonstrated more *child positive affect* (*n*=2-3), gave more *commands* to his mother (*n*=1-2) and asked fewer *questions* (*n*=1-4) in most sessions compared to baseline. At post-intervention, Child 11 showed more *child positive affect* (*n*=4) and more *child commands to parent* (*n*=2) but *child questions parent* (*n*=1) compared to his baseline.

Table 27

Scores of Family 11 on the Standardised Measures across Experimental Conditions

Measures	B	PI	FU1	FU2
ECBI-Parent Intensity score	**130** (**60**)	108 (46)	X	X
ECBI-Parent Problem score	8 (51)	5 (41)	X	X
PSI-SF (P-CDI) Score	18 (32)	14 (14)	--	X
JPSCS Total Score	39 (62)	40 (73)	--	X

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI-SF and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- = score is not collected as scheduled; X=data were not available due to drop-out; ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline; PI= Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 11's per the ECBI *Intensity* scale (*T-score* = 60) was at clinically significant levels. Parent 11's *Parent Child Dysfunctional Interaction* score of PSI-SF was in normative range. Child 11's JPSCS score was classified as *moderate positive* self-concept. At post-intervention, clinically significant change was evident in the ECBI *Intensity* score (*T-score* = 46), it reduced to non-clinical levels. Child

11's JPSCS score was remained in the classification of *moderate positive* self-concept and Parent 11's *Parent-Child Dysfunctional Interaction* score of the PSI-SF remained in the normative range. Follow-up scores for all measures were unavailable as the Paret 11 discontinued in the study.

Summary of Family 11. Parent 11 completed the intervention with a moderate homework completion rate of 61.5%. She improved in five of the seven strategies, including *reflective statements, behavioural descriptions, information questions, commands* and *esteem-building* responses across phases. No improvement was observed in two other strategies as Parent 11 had no opportunities for implementation. Overall, a substantial improvement in *non-directive* response was evident in Parent 11. Child 11 demonstrated more *child positive affect*, more *child commands* to *parent* but fewer *child questions parent* after the implementation of intervention. At post-intervention, improvement was evident in all standardised measures. Clinically significant change was evident in parent perceived child behaviour as per ECBI, as well as an increase in child self-concept and a reduction in parenting stress related to difficult parent-child interaction.

Family 12.

Observed parent responses across phases. The parent's DPICS responses across the phases are displayed in Figure 75. There was improvement evident across the phases in five out of seven strategies, including *reflective statements, behavioural descriptions, information questions, commands* and *esteem-building* responses.

Skills taught in Session 1.

Reflective statements. At baseline, Parent 12 made a *reflective statements* (*n*=1). This was followed by an immediate increase in *reflective statements* from Session 1 (*n*=8) to Session 4 (*n*=17), which continued up to post-intervention (*n*=23).

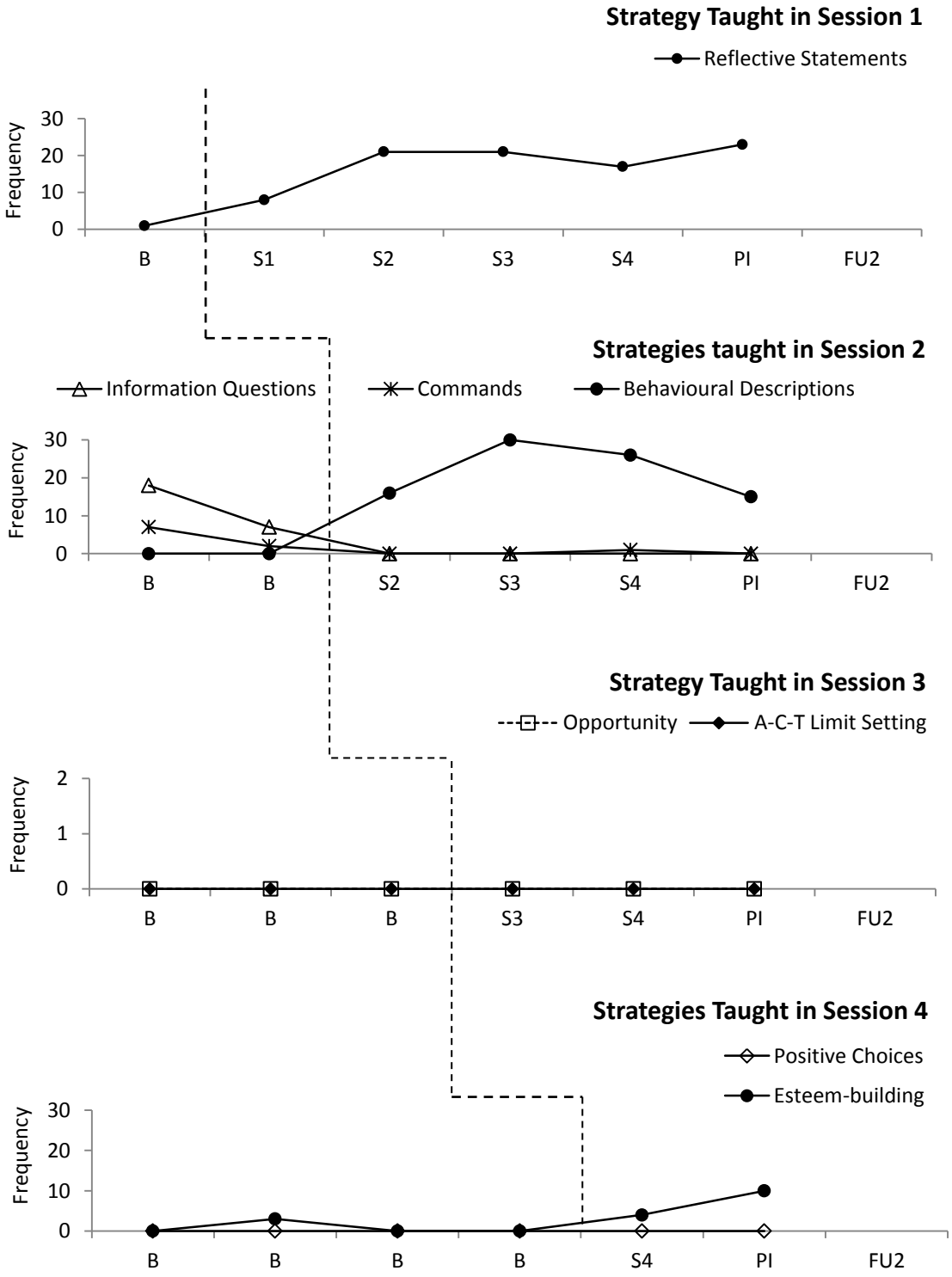


Figure 75. Parent 12's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. Opportunity shown in Session 3 was not a strategy taught in the session but represents the number of chances to implement the A-C-T limit-setting strategy. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Skills taught in Session 2.

Behavioural descriptions. At Baseline, Parent 12 did not demonstrate any *behavioural descriptions* (*n*=0). This was followed by a sharp increase in *behavioural descriptions* during intervention (S2, *n* =16; S3, *n*=30; S4, *n*=26), which continued until post-intervention (*n*=15).

Information questions. At baseline, Parent 12 predominantly asked *information questions* (*n*=7-18). Parent 12 omitted from asking *information questions* from Session 2 to post-intervention.

Commands. Parent 12 made more *commands* in early baseline (*n*=7) and less towards the end of baseline (*n*=2). This was followed by low levels of *commands* throughout the intervention (*n*=0-1) which continued at post-intervention (*n*=0).

Skills taught in Session 3.

A-C-T limit-setting. Parent 12 had no opportunities to demonstrate *A-C-T limit setting* throughout the experimental period as Child 12 did not engage in any inappropriate behaviours.

Skills taught in Session 4.

Esteem-building. At baseline, Parent 12 showed low levels of *esteem-building* responses in general. This was followed by an immediate increase in Session 4 (*n*=4) which further increased at post-intervention (*n*=10).

Positive choices. Parent 12 did not give *positive choices* to Child 12 before and after it was taught.

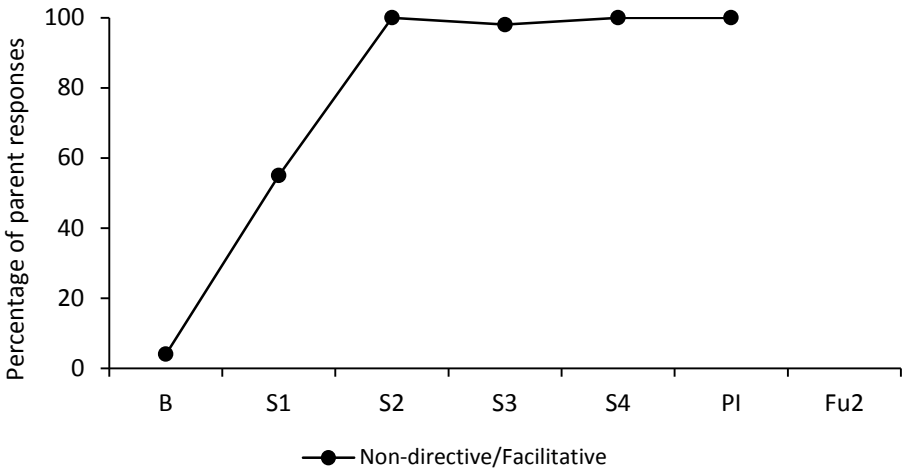


Figure 76. The percentage of non-directive responses of Parent 12 during the 5-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Non-directive parent responses. At baseline, Parent 12 demonstrated low levels of *non-directive* responses (*n*=1; 4%). When intervention occurred, an immediate increase in *non-directive* responses was evident (S1, *n*=11; 55%) and it continued to increase markedly during the intervention (S2, *n*=37; 100%; S3, *n*=57; 98%; S4, *n*=47; 100%). Parent 12 remained 100% *non-directive* responses at post-intervention (*n*=48).

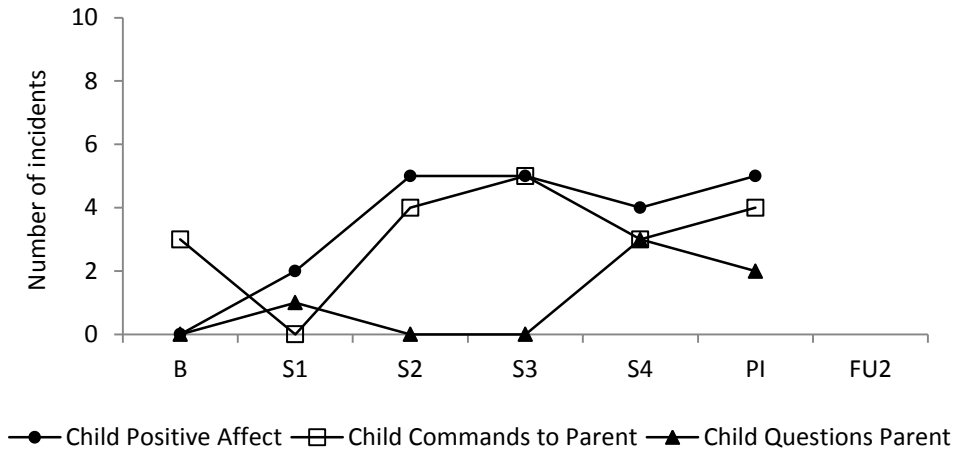


Figure 77. Child 12's DPICS responses during the 5-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Observed child responses. At baseline, Child 12 gave few *commands* (*n*=3) to his mother while she did not show any *child positive affect* and *child questions parent*. When intervention occurred, Child 12 demonstrated more *child positive affect* (*n*=2-5), gave more *commands* (*n*=4-5) to his mother from Session 2, than she had in baseline, while she asked few *questions* at times (S1, *n*=1; S4, *n*=3). At post-intervention, Child 12 demonstrated more *child positive affect* (*n*=5), more *child commands to parent* (n=4) and more *child questions parent* (*n*=2) compared to baseline.

Table 28

Scores of Family 12 on the Standardised Measures across Experimental Conditions

Measures	Baseline	Post-intervention	Follow-up I	Follow-up II
ECBI-Parent Intensity score	**178** (**73**)	109 (54)	98 (50)	59 (39)
ECBI-Parent Problem score	22 (**69**)	2 (43)	2 (43)	1 (42)
PSI-SF (P-CDI) Score	24 (58)	15(18)	--	13 (10)
JPSCS Total Score	24 (3)	32 (16)	--	X

Note. Raw scores are presented. ECBI data in parenthese are T-scores; 60 and above denote clinical significance levels of ECBI and are shown in bold. PSI and JPSCS data in parenthese are percentile scores. Percentile scores of 80-84 denote borderline; 85 and above denote clinical significance levels of PSI-SF and are both shown in bold. Lower scores in ECBI and PSI indicate improvement in child behavioural problems and parenting stress, respectively. Higher scores in JPSCS indicate improvement in child self-concept. -- =score is not collected as scheduled; X=data were unavailable as the participant discountinued the study; ECBI=*Eyberg Child Behavior Inventory*; PSI-SF=*Parent Stress Index-Short Form*; P-CDI=*Parent-Child Dysfunctional Interaction* scale; JPSCS=*Joseph Picture Self-Concept Scale*; B=Baseline, PI=Post-intervention; FU1=Follow-up 1; FU2=Follow-up 2.

Child and Parent Functioning. At baseline, Child 12's ECBI *Intensity* (*T-score*= 73) and *Problem* (*T-score*= 69) scores was at clinically significant levels. Parent 12's *Parent-Child Dysfunctional Interaction* score of PSI-SF was in the normative range, while Child 12's JPSCS score was classified as *very high-risk negative* self-concept. At post-intervention, Child 12's *Intensity* (*T-score*= 54) and *Problem* (*T-score*= 43) reduced markedly and they were both at non-clinical levels. The parent's *Parent-Child Dysfunctional Interaction* score was remained in the normative range. While the child's JPSCS score increased by 13 percentile score, that score remained in the classification of *very high risk negative* self-concept. Parent's ratings on the child's behaviour continued to reduce at post-interevntion and Follow-up 2.

Summary of Family 12. Parent 12 completed the intervention with a moderate homework completion rate of 92%. She improved in five out of seven strategies, including *reflective statements*, *behavioural descriptions*, *information questions*, *commands* and *esteem-building* responses across phases. Parent 12 has no opportunities to implement *A-C-T limit-setting* as Child 12 did not misbehave and *positive choices* as not observed after it was taught. Overall, a substantial improvement in *non-directive* response was evident in Parent 12. Child 12 showed more *child positive affect*, more *child commands to parent* and more *child questions parent* after the implementation of intervention. Clinically significance change was evident in parent perceived child behaviour per ECBI at post-intervention. Likewise an increase in the self-report scores of parenting stress and child self-concept as per JPSCS at post-intervention, while no changes was noted at clinical levels. While improvement in the incidents of non-compliance and temper-tantrums was noted in Child 12, no noticeable changes were found in the incidents of fighting within the intervention phase. Child 12's *Intensity* score continued to decrease at follow-ups.

Summary of the Within-Participant's Results

Seven out of eight parents completed the intervention with a high homework completion rate. Of that, five out of seven parent-child dyads completed all the measures at each phases. Overall, with implementation of intervention, all parents increased in *non-directive* responses. Most of them showed consistent improvement in most of the taught strategies whenever possible, expected one who did not maintain her gains in *reflection statements* and *estem-building* strategies at times. As consistent with the objective of adapated CPRT, none of the parents gave *positive choices* to their children and only one parent had the opportunities to implement *choice-giving as consequences* during parent-child play obseravtions. In addition, all parents showed an immediate reduction in asking *information questions* and six of them made immediate reductions in *commands* after they

were taught to omit these responses, while one parent maintained her zero levels of commands at baseline across the intervention phase. Consequent to the parents' improvemenets, all children demonstrated an increase in *child positive affect*, six of them increased in *child commands to parent* and four of them reduced in *child questions parent*, while two other children remained zero to low levels of *child questions parent*.

Chapter 6: Discussion and Conclusion

There are four main areas of discussion presented here. The first two sections are organised around the two overarching themes of the research questions. The first section discusses the findings of the parent behaviour diary and standardised measures for each participant pertaining to the question of whether the adapted programme was effective across the participants. This includes the changes in child behaviour outside the parent-child play sessions, child self-concept and parental stress. The second section discusses the findings of the video-recorded parent-child play sessions pertaining to the question of how the programme worked within the participants. This includes changes in parent behaviour and the corresponding changes in child behaviour and play during the video-recorded parent-child play sessions. The third section pertains to the overall effectiveness of the proposed module of the 5-session adapted CPRT, where parent attribution and parent retention are discussed, in addition to the overall findings of Study 2. The exception to the overall pattern of improvement in parent and child behaviours is then discussed in the final section. In light of the findings, limitations and implications for practices and future research were discussed. Then, conclusion was made.

Targeted Positive Child Behaviour

The first research question the study addressed was the effectiveness of the adapted CPRT on targeted positive child behaviour across participants. The results of Study 2 suggest that adapted CPRT was effective in promoting positive changes in child behaviour. Child 5 showed improvements in one or more of the parent-targeted positive behaviours, and this was replicated across all children whose parents completed the intervention; including improvements in compliance, playing independently, playing nicely with others and putting toys away. In addition, five out of six children were either further improved or maintained their gains at post-intervention or Follow-up 2. These findings suggest that the children had

been benefited from the intervention through parent-child play sessions and thus extended their positive experience into their day-to-day living by increasing positive behaviour. In the original CPRT, the change in the child's behaviour is considered to be a byproduct of the improved relationship and positive self-concept on the part of the child, thus no studies, to the knowledge of the researcher, have documented the effect of CPRT on increasing a child's positive behaviour on a daily basis as shown in Study 2. The results of Study 2 indicate the strength of adapted CPRT in facilitating children to make and sustain positive changes in their behaviours in the real world.

Targeted Negative Child Behaviour

The second research question the study addressed was the effectiveness of the adapted CPRT on targeted negative child behaviour across participants. Over the course of the study phases, Child 6 showed reductions in problem behaviours, and such reductions were replicated across six out of seven children, including behavioural targets of temper-tantrums, attention-seeking, aggression, interrupting, and arguing. In addition, five out of six children were either further improved or maintained their gains during the post-intervention or follow-up phases. These results suggest the children had successfully expanded the positive experience they obtained in the parent-child play sessions into their day-to-day living by reducing their negative behaviour. The results, replicated across most children and across behaviours, indicate the strength of the relationship between the intervention and the outcomes for child behaviour. While some early studies of FT and CPRT were targeted at parents of children with behavioural problems (e.g., Athanasiou & Gunning, 1999; Boyer, 2011; Moses, 2013; Sensue, 1981; Sywulak, 1978; Johnson-Clark, 1996 in VanFleet et al., 2005), none of these studies have incorporated similar measures of child behavioural changes, such as *Parent Behaviour Diary*, to document children's progress across the intervention as demonstrated in Study 2.

Parent-reported Child Behaviour Problems

The third research question the study addressed was the effectiveness of the adapted CPRT on parent-reported child behaviour problems across the participants. Clinically significant changes in parent-reported child behavioural problems were demonstrated in all children following the 5-session adapted CPRT. In particular, all seven children were rated by their parents at clinical levels of behavioural problems at baseline. After the intervention, there were reductions in ECBI *Intensity* and *Problem* scales, with five of the seven completing children showing clinically significant improvement. In addition, all six children showed clinically significant change in their behaviours three months following the intervention.

The results of Study 2 are similar to those found in Moses' (2013) study. In that study, five out of seven children's behaviour were rated at clinical levels on ECBI at baseline. At post-intervention, four out of five children's rating decreased to normative range. Three children' ratings, whose parents' completed the 1-month follow-up measure, remained in the normative range. Adding on to the positive findings on child behavioural change in Moses' (2013) study, the clinically significant changes in child behaviour problems found in Study 2 provide further support for the effectiveness of short-term FT as a parental programme for parents of children with clinical levels of behaviour problems, a group which has not been specifically studied previously.

One possible reason for the positive findings on child behaviour in Study 2 and Moses' (2013) study is that there were high numbers of parent-child play sessions within a short period of time. The parents in Study 2 have been supported in delivering at least two parent-child play sessions each week since the completion of the second intervention session. In general, the parents conducted at least eight parent-child play sessions in four consecutive weeks, including those of the data collection sessions. Similarly, parents in Moses' study

were required to conduct seven parent-child play sessions in four consecutive weeks. This level of intensity of parent-child play sessions conducted by the parents in Study 2 may be comparable to the 10-session intensive CPRT in published studies. For example, parents in Kidron and Landreth's (2010) study conducted approximately eight parent-child play sessions over five weeks and parents in Smith and Landreth's (2003) study delivered about 11 play sessions in two to three weeks. These two quantitative studies reported statistically significant decreases in externalising behaviour of the children in the experimental groups compared to those in the non-treatment control groups.

Smith and Landreth (2003) suggested that filial therapy when conducted in an intensive manner allowed children to rapidly process their inner feelings and desires using play with the presence of their mothers' acceptance. In the 5-session adapted CPRT, a parent-child play session is the time and place for a parent to practise the taught strategies and principles. Therefore, if a parent conducts play sessions with his or her child more frequently in a short timeframe, the parent would have more opportunities to implement the taught strategies and principles repeatedly and thus master them. As for a child, having more play sessions with the parent means that the child would have more chances or time to process his or her inner feelings and to perceive positive regard from the parent. The results of Study 2 indicated that the higher number of parent-child play sessions the parents conducted might have allowed them to refine their play session skills and thus facilitate rapid and substantial changes in their children's behaviours, even though they received relative fewer intervention sessions compared to the 10-session intensive CPRT in published studies (Kidron & Landreth, 2010; Smith & Landreth, 2003).

The findings of Study 2 showed more clinically significant reductions in the children's behavioural problems compared to other studies of group filial therapy for parents of children with behavioural or emotional problems, including tantrums and shyness (Athanasiou &

Gunning, 1999; Dillman Taylor, Purswell, Lindo, Jayne, & Fernando, 2011). Dillman Taylor et al. (2011) reported that all three children showed reductions in externalising problems from the clinical to the borderline range on CBCL, after their parents attended 10 group-sessions. In another study, one of two children showed clinically significant reductions in externalizing behaviour at post-intervention, on the BAS, following a 10-week individualised LFT (Athanasiou & Gunning, 1999). Both Dillman Taylor et al. (2011) and Athanasiou and Gunning's (1999) studies showed encouraging changes in child behaviour after filial therapy in some children and thus provide some additional evidence of the effectiveness of filial therapy in producing clinically significant reductions in child behavioural problems. The findings of these studies were not as strong as those found in Study 2, where all six children showed clinically significant reductions in their behaviour problems three months following the intervention, even though the parents in Study 2 received half the numbers of intervention sessions than those in Athanasiou and Gunning's (1999) and Dillman Taylor et al. (2011) studies. This could be because the adapted CPRT in Study 2 was delivered in an individual format, which was also reported in Moses' (2013) study. The individual format of adapted CPRT might have provided sufficient levels of focus to address the specific child behavioural problems encountered by each parent. As a result, it helps the parents to reduce their child's problematic behaviour and thus reduce parent-perceived child behavioural problems.

The positive outcomes on child behavioural problems in Study 2 were stronger than the findings of other filial therapy studies which did not include children with defined behavioural problems (e.g., Grskovic & Goetze, 2008; Topham et al., 2011). For instance, Topham et al. (2011) reported seven to eight children improved and 15-16 children did not improve in externalising behaviour after their parents attended a 10-session individualised VanFleet's filial therapy. Grskovic and Goetze (2008), however, found no significant difference in *Externalising* scale between children in the experimental group, whose parents

attended an intensive 8-session VIFT, and the control group. Differently from Study 2, children in these studies were selected based on their age, which was between 2 and 14 years, and on whether their mother was experiencing a wide range of parental stress as in Grskovic and Goetze's study (2008), rather than being selected for behavioural problems. Together, these indicated that filial therapy might be more effective in improving the behaviour of children with clinically significant behavioural problems than those without.

Child Self-Concept

The fourth research question the study addressed was the effectiveness of the adapted CPRT on child self-concept across the participants. Beneficial changes in child-reported self-concept after the intervention were demonstrated in Study 2. To be specific, five children improved or maintained a positive self-concept, and the other two showed a reduction in negative self-concept. Positive change in child self-concept is perceived as an indicator for a lasting personality change in person-centred therapy (Rogers, 1942). This suggests that the 5-session adapted CPRT promotes constructive changes in children, in terms of self-concept.

Studies found that preschool children with higher levels of behaviour problems have lower levels of self-concept (C. Barry et al., 2003; Breitenstein et al., 2009; Webster-Stratton & Herbert, 1994). In addition, Cauley and Tyler (1989) found that children, aged between four and five years, who reported higher levels of self-concept demonstrated more cooperative behaviour during free play than those with lower levels of self-concept. Thus, higher self-concept is associated with fewer behaviour problems and more cooperative play. Based on the results of these studies, a child's self-concept is related to behaviour problems. Thus, the improved child self-concept in children with clinical levels of behaviour problems in Study 2 might be a contributing factor for the success of the adapted CPRT. Therefore, the results of Study 2 extend support for using FT to achieve positive self-concept in children with clinical levels of behavioural problems.

The findings of Study 2 are consistent with a study of an intensive filial therapy (Smith & Landreth, 2003) which reported significant improvement in self-concept among children in the experimental group as compared to children in the non-treatment comparison group at post-therapy. One plausible reason for the positive changes in child self-concept reported in Smith and Landreth's (2003) and Study 2 may be related to the high number of parent-child play sessions in a short period of time. In Smith and Landreth's (2003) study, each parent-child dyad had approximately 11 play sessions in two to three weeks. The parents in Study 2 had at least four home play sessions with their children in four weeks as part of the intervention and an additional four play sessions with their children at the clinic for the purpose of data collection. These findings point to the possibility that the high number of parent-child play sessions in a short period of time in Study 2 might have helped promote a persistent therapeutic relationship between the parent and child, which is needed to produce a positive change in child self-concept.

Study 2's results support Rogers' (1939, 1963) assumptions that when a child achieved the fundamental need for parental affection, the child would increase his or her self-regard and thus exhibit a more positive perception of self, as a sign of a successful therapy. In line with Rogers' assumptions, Axline (1947) proposed that positive self-image and self-regard on the part of the child could be promoted if the child perceived a sense of acceptance of being him or herself within a therapeutic parent-child relationship. Bernard Guerney (1964) added that parents' intentional attention to the child and the child's needs in play sessions would lead to an improved child self-concept. The improved child self-concept after adapted CPRT implies that the parents have successfully established a positive social experience for their children using child-centred play sessions.

Parenting Stress Related to Parent-Child Dysfunctional Interaction

The fifth research question the study addressed was the effectiveness of the adapted CPRT on parenting stress across the participants. All parents in Study 2 reduced self-reported stress related to parenting, particularly parent-child interaction, following the conclusion of the intervention, including two parents at the clinical levels at baseline. This improvement was either maintained or continued to improve for another three months. This evidence suggesting that the implementation of adapted CRPT may be a contributing factor for the reductions in parenting stress related to parent-child interaction, which is consistent with recent CPRT studies using both the original group model of CPRT and an adapted individual model of CPRT.

The findings of Study 2 are consistent with some recent studies of CPRT. For instance, in a single-subject study (Moses, 2013), improvement in parenting stress related to parent-child interaction was noted in five out of seven parents, with four reporting a clinically significant reduction. While two other filial therapy studies (Dillman Taylor et al., 2011; Kidron & Landreth, 2010) reported significant changes in total parenting stress on PSI-SF following a 10-session intervention, no information was provided regarding the changes on the parent-child dysfunctional interaction subscale. The positive changes in parenting stress following the intervention in Moses' study (2013) and Study 2 suggest that the CPRT, even though adapted, is an effective intervention in reducing parenting related stress, particularly in parent-child interaction.

In line with the transactional relationship between parenting stress and child behavior problems (Neece et al., 2012), the findings in Study 2 indicated that reduced parenting stress, particularly on parent-child interaction resulted in more positive parent evaluations of their child's behaviour. These are consistent with those found in a single-case study of a short-term adapted CPRT, which demonstrated a decrease in parental stress in relation to parent-

child interaction and child externalising behaviour following therapy (Moses, 2013). A potential explanation for the positive effects of FT on parenting stress in relation to parent-child interaction and child behaviour is the number of intensive parent-child play sessions in both studies within a short timeframe. While adapted CPRT in Moses' study (six sessions) and Study 2 (five sessions) were somewhat equivalent to half the sessions of the 10-session intensive CPRT in Kidron and Landreth's (2010) study, three therapeutic protocols required parents to conduct on average, seven to eight parent-child play sessions in four consecutive weeks. The findings indicated that intensive parent-child play sessions over a short period of time might have provided sufficient opportunities for parents to rapidly practise the taught strategies, which in turn produced substantial changes in their children's behaviour problems. The reductions in child behavioural problems would have increased the parents' perception of their parenting competence and thus reduced their stress related to parenting.

All parents in Study 2 indicated the parent-child play sessions were important in helping them to execute the taught strategies. Parent 5 said that she felt good about herself as she knew how to respond to her son's tantrums, which she got to practise during the play sessions. Parent 8 disclosed that being able to reflect her son's feelings and wishes inside and outside of the play sessions helped her son to eliminate his tantrums and misbehavior and thus made her feel more relaxed when being with him. Similarly, a mother in Kidron and Landreth's (2010) study indicated that being able to be honest with her own feelings while being with her daughter made her feel less anxious. Another mother expressed that she learned to understand and accept her daughter as she is by being less judgmental. In Moses' study, reductions in parent reports of child behavioural problems on ECBI were found for three out of seven parents after the implementation of play sessions. Therefore, it is possible that the intensive number of parent-child play sessions during a short intervention period in supporting the parents to implement the taught strategies and possibly increase parents' sense

of competency, is associated with the decrease in parenting stress related to parent-child interaction and the corresponding reduction in child behaviour problems.

Parents' Use of the Child-Centred Play Strategies

The sixth research question the study addressed was the effectiveness of the adapted CPRT on parent's use of the child-centred play strategies in the video-recorded parent child play sessions. The seventh research question of Study 2 was pertained to "What is the relationship between any changes in parent's use of the child-centred play strategies in the video-recorded parent child play session and the teaching of these strategies in the curriculum?"

All parents in Study 2 showed reductions in directive responses, such as commands and information questions, and increases in non-directive or facilitative responses, including *reflective statements*, *behavioural descriptions* and *encouragement*, at post-intervention and Follow-up 2. Likewise, in an early study of FT (Stover & Guerney, 1967), the observation data showed that the mothers in the experimental groups decreased in an average of 45% of directive responses, including command, suggestion and advice. While not directly comparable, in a quantitative study of a short-term VIFT (Grskovic & Goetze, 2008), parents in the experimental group showed a significant increase in using non-directive responses to specific situations in play sessions, which was not reported by parents in the comparison group. Together, the findings of these studies support the finding of Study 2 that FT is effective in increasing the parents' use of child-centred play strategies.

A clear relationship is shown between changes in parents' use of the child-centred play strategies during parent child play sessions and the teaching of these strategies in the curriculum of adapted CPRT, in the use of *reflective statements* taught in Session 1 (three parents showed immediate improvement and the other parents showed improvement in the following weeks), *behavioural descriptions* taught in Session 2 (all parents showed

immediate improvements), *A-C-T Limit-Setting* taught in Session 3 (improvement for all parents who had a chance to implement the strategy), *esteem-building* taught and *choice-giving* taught in Session 4 (All parents showed improvement, either immediately after the training session or at post-intervention; one parent had the opportunity to use *choice-giving as consequences* strategy and did so). With the implementation of the intervention, in general, all parents demonstrated improvement in all taught strategies whenever possible during the parent-child play sessions. In addition to the improvement in taught strategies, all parents showed an immediate reduction in asking information questions and six out of seven parents made immediate reductions in commands after they were taught to omit these responses during the child-centred play sessions in Session 2, while one parent maintained her zero levels of commands at baseline across the intervention phase.

The findings of Study 2 are consistent with other FT studies that demonstrated observed increases in taught strategies among parents (Grskovic & Goetze, 2008; Kidron & Landreth, 2010; Smith & Landreth, 2003; Stover & Guerney, 1967), including an unpublished work (Moses, 2013). Using the same observation measure as in Study 2, Moses (2013) reported that five out of seven parents who attended six individual sessions of CPRT improved in positive behaviour, including *behaviour descriptions* and *reflections*, and reduced in giving direct commands, from pre-intervention to post-intervention. Other than that, pre- and post-observational data in Grskovic and Goetze's (2008) study showed that mothers who attended a brief form of the VIFT, in addition to counselling services as received by those in the control group, increased significantly in reflecting their children's actions, verbalizations and feelings. Similarly, Stover and Guerney (1967) found that mothers who received GGFT increased significantly in reflective statements, which included restatement of content and clarification of feeling.

Other studies indicated positive changes in parent behaviour using a different coding system–the MEACI. This system measures changes in parent behaviour related to filial therapy's goals. This is different in an important way as parent behaviour related to a specific strategy or a collective of strategies and attitudes taught in FT is rated to determine the degree of achievement in each subscale, namely communication of acceptance, allowing self-direction and involvement. For example, communication of acceptance is coded when a parent makes *reflective statements* and or *behavioural descriptions*, while an improvement in allowing self-direction denotes reductions in giving commands. Therefore, results from the MEACI can provide an indication of improvement in some strategies taught in filial therapy, which is rated to reflect the quality of skill implementation rather than the frequency of strategies used by parents as coded in DPICS.

Moses (2013) noted improvements in five out of seven parents on communicating acceptance, allowing the child self-direction and involvement in child play across all parents during intervention phase. Similarly, Kidron and Landreth (2010) found that parents who received intensive CPRT scored significantly better than parents in the control group. In Smith and Landreth's (2003) study, mothers who received 10-week LFT demonstrated significant improvement in communication of acceptance and allowing the child self-direction. All parents who completed 10-session VIFT in Topham, Wampler, Titus and Rolling's (2011) study improved in communicating acceptance, although this was the only parent behaviour coded. These studies documented increases in parental behaviour associated with parent empathy that allied with goals of filial therapy.

However, as far as can be determined, none of the existing FT studies have studied the relationship between the intervention-trained strategies and changes in parent behaviour. Also, no studies have shown data that identifies as convincing a relationship between the intervention and changes in parent behaviour, as shown in Study 2. For example, some

studies (e.g., Grskovic & Goetze, 2008; Moses, 2013; Stover & Guerney, 1967) reported parents' acquisition of a few of the targeted strategies, such as reflective statements and behavioural descriptions, while others (e.g., Kidron & Landreth, 2010; Smith & Landreth, 2003; Topham et al., 2011) observed parents' behaviour changes, such as parental empathy and parental acceptance in pre- and post-intervention sessions. While measuring parents' attainment of intervention goals at the conclusion of FT could inform parents' overall gains in the intervention, the information regarding the parents' progress in learning each strategy to accomplish the goals, which could provide a clearer picture of what and how parents learn, is missing. Unlike other FT studies, Study 2 systematically documented the process of parent skills acquisition by demonstrating parent behavioural changes which corresponded to the strategies taught in each intervention session using single-subject designs.

Unlike other FT studies, Study 2 demonstrated convincing findings on the maintenance of acquired child-centred play or FT strategies in each participated parent. While supporting the positive findings in two previous studies which indicated increased reflective statements and reduced directive comments in parents after they attended three and five training sessions, respectively (Grskovic & Goetze, 2008; Stover & Guerney, 1967), the findings of Study 2 showed that the parents' gains in reflective statements and reductions in directive responses continued to improve across the intervention phase and remained stable three months following the intervention. However, this was not reported in either Stover and Guerney's (1967) or Grskovic and Goetze's (2008) studies. This finding of Study 2 is strong evidence suggesting that the 5-session adapted CPRT, even though was somewhat equivalent to half the sessions of the original CPRT, is sufficient in helping parents attain the basic child-centred play strategies.

Children's Responses during Parent Child Play Sessions

The eighth research question, which pertains to "Are there corresponding changes in children's responses during the video-recorded parent child play sessions?" Six out of seven children increased in *child commands to parent* and four children reduced in *child questions parent*, while two children remained at zero to low levels of *child questions parent*, once the parents implemented the taught strategies and reduced in asking information questions and giving commands. The changes in child behaviour consequent to the changes in parent behaviour were consistent with Axline's (1947) principles for play therapy in forming the therapeutic relationship that lead to positive self-directed change in the child. Axline (1947) indicated that when an adult accepted and valued a child fully and reduced his or her directedness toward the child during sessions, the child would direct the sessions and thus entering the healing process.

Increases in *child commands to the parent* and decreases in *child questions to the parent* might be an indication of positive therapeutic outcomes. Rogers (1951) defined behaviour "as to meeting the needs of the self" (p. 493) and thus an increase in a child's assertive behaviour, as demonstrated by given the parent commands instead of asking the parent questions, within a therapeutic experience is a sign that the child is moving toward self-directed growth (Rogers, 1942). Specifically, Stover and Guerney (1967) defined assertiveness of children in play sessions with their mother as increases in leadership, if the "child suggests, instructs, directs, gives ideas, guidance, or otherwise asserts himself with the adult." Similarly, reductions in dependency in verbalization, are also indications of assertiveness; demonstrated if the "child requests evaluation or praise, instruction, direction, ideas, guidance or leadership from the adult (Stover & Guerney, 1967, p. 112). Taken together, the recorded behavioural changes in the children in the parent-child play sessions in Study 2 could be a conscious and positive movement taken by the children toward the need of

becoming self-governed. Therefore, the results of Study 2 can be interpreted to support Stover and Guerney's (1967) idea of the positive impacts of parent behavioural changes associated with child-centred play and FT strategies, on child assertiveness during play sessions. These results are consistent with the theoretical assumptions of person-centred therapy in regard to self-directed growth within a therapeutic parent-child experience.

The results of Study 2 support the findings of a quantitative study of FT (Grskovic & Goetze, 2008), which indicated that children in the experimental group reduced in asking their parents questions while the parents increased in uisng reflective comments. Of that, an approximately 38% reduction in *child questions parent* was recorded in the experimental group children. However, change in children's frequency of asking questions was used as an outcome measure and was assessed following the fifth parent-child play sessions. The present study, on the other hand, measured changes in *child questions parent* following each intervention session and a decreasing trend in *child questions parents* was shown in most children from the first or the second parent-child play session. Consistent with person-centred theory, the findings of Study 2 demonstrated that the children became more independent and self-directed in play sessions, by reducing the need for parent's guidance or assistance, when the parent increased in non-directive responses, such as *reflective statements*.

Improvement in child's emotional expression during the parent-child play sessions consequent on the positive changes in parent behaviours shown in Study 2 was consistent to the hypothesised process of personality change in person-centred therapy. As one example of the changes in emotional expression, all seven children in Study 2 demonstrated an increase in child positive affect, once their parents implemented the taught strategies. To person-centred therapy (Rogers, 1942), the corresponding improvements in child positive affect and

parent behaviour in Study 2 indicated the children's movements toward positive emotional expression as a response to the new parent-child relationship.

The results of Study 2 contrasted with the finding of an early study of FT (Stover & Guerney, 1967). In that study, child negative emotion was found to increase in the fourth play session when the parents increased in reflective comments and reduced in directive comments, as compared to the first play session. While similar positive changes in parent behaviour in parent-child play sessions were found in Study 2 and Stover and Guerney's study, the present study found a positive trend in child affect across the experimental period. It appears that, despite the similar gain in FT strategies made by the parents in both studies, it was claimed to be contributed to an opposite form of changes in child emotional expression.

One possible reason for the differences between the findings of Study 2 and the findings of Stover and Guerney's (1967) is that the latter measured the changes in different stages of the intervention. Study 2 coded a total of seven play session observations while only four play-session observations were coded in Stover and Guerney's (1967) study. In Study 2, an increasing trend in child affect toward their parents was observed during the intervention phase, while an increase in child negative affect was found at the fourth play session in Stover and Guerney's study. The deviation in findings of child emotional expression which corresponded to the gains in parent behaviour in both studies may indicate that the children were making progress in different stages of FT.

In regard to person-centred philosophy, changes in one's emotional expression during a therapy could be an indicator of progress. Specifically, Rogers (1942) hypothesised that an individual is more likely to increase in their expression of positive affect after he or she has processed or expressed his or her inner desires or negative emotions in a therapeutic relationship. Moustaka (1973) affirmed that an expression of negative emotions is the first step of change by maladjusted and aggressive children in play therapy, while positive

emotions generally emerge later and continue to be expressed in the final stage. In general, both movements toward positive changes in therapy identified by Rogers and Moustaka were illustrated in Stover and Guerney's (1967) study and Study 2.

A possible explanation for the increases in child positive affect in the present study is the persistence of parents' use of child-centred play strategies, which maintains the parent-child dynamic in the play sessions, thus strengthening the parent-child relationship. As a result, the relationship becomes therapeutic for both of them and therefore the child is more likely to increase in positive affect. This is in line with the principles of person-centred therapy (Rogers, 1942, 1949) and CCPT (Axline, 1947), which indicated that a parent could convey his or her acceptance of his or her child to the child through implementation of the child-centred strategies. Consequently, the child would be more likely to perceive the parent's positive regard. When this dynamic occurs, the parent-child dyad is more likely to enjoy each other and thus develops a joyful relationship, which could be shown by their responses to each other. This hypothesis is supported by Trawick-Smith's (1998) assumption that the way an adult relates to a child during play sessions influences the child's behaviour, which subsequently modifies the adult's mode of communication. In the light of the findings in Study 2, increases in child positive affect directed to the parent and the persistence of parents' use of child-centred play strategies in play sessions may signify the child's and the parent's responses toward the establishment of the therapeutic parent-child relationship, as hypothesised by Trawick-Smith (1998) and Axline (1947).

Parents' Experiences and Perceptions of Adapted CPRT

All parents in Study 2 made positive comments about the programme during parent feedback interviews. They thought the programme was "helpful", "positive and beneficial", "great" and "fantastic". Three parents said they would "love" to see the Ministry of Education use this programme, especially at schools and preschools and even in weekend

workshops. One parent said that she would "highly recommend it to all parents and teachers working in ECE…it should become part of the Bachelor's Degree in Early Childhood Education". These positive comments from the parents reflected their gratification for adapted CPRT. The potential satisfaction of the parents in Study 2 suggested that short-term filial therapy could be an alternative and preferable choice of treatment for parents of children with behaviour problems.

Study 2's findings revealed a possible relationship between parents' positive feedback about the intervention and the general parent retention. However, it is difficult to tell from the available data about parent retention conclusively, because it was not directly measured in Study 2. By saying this, seven out of eight (87.5%) families who participated in Study 2 completed the 5-session adapted CPRT. The families who completed the intervention showed a 100% attendance rate. The possible relationship between the parents' gratification for adapted CPRT and their high retention is consistent with the strong positive correlation between retention and satisfaction reported in Topham and Wampler's (2008) study. The results of Study 2, together with the findings revealed in Topham and Wampler's study, indicated than the high retention rate among parents in Study 2 is an indicator of the parents' satisfaction with adapted CPRT.

More parents retained in Study 2 compared to other studies of filial therapy. In Smith and Landreth's (2003) study, 11 out of 14 mothers (79%) completed the 10-session intensive filial therapy offered in the shelters where the mother-child dyads were staying. Unlike Smith and Landreth's study, the present study provided two out of five sessions at the participants' homes. It could be that the parents in Smith and Landreth's study were the victims of domestic violence in addition to their child's behavioural problems. It could also be that adapted CPRT in Study 2 included home visits, which may be a contributing factor to high retention in parents.

The high rates of retention in Study 2 contrast with findings from Topham and Wampler's (2008) study. Overall, only 40% of the participants completed all 10 sessions of filial therapy in Topham and Wampler's study. The reason Topham and Wampler might have had so many drop-outs is because they required parents to attend 10 sessions. In contrast, Study 2 might have had better retention because it used a 5-session version of FT. The authors attributed their low retention to using individual sessions instead of group sessions. However, the present study used an individual format and retention was high.

The value of individual sessions was further identified in a meta-analysis (Koerting et al., 2013). In that study, group activities were found to be one of the reasons that stop parents' continued engagement in a parenting group. For instance, some parents found it hard to maintain cohesion in a group due to inconsistent participation of other parents, while other parents found it hard to share their concerns in a group or attain a sense of belonging. These obstacles are likely to be addressed in an individual format of parenting programmes, such as the one provided in the present study. Differently from Topham and Wampler's (2008) suggestion, the present study recommends that the provision of individual therapy is better in retaining parents than group therapy.

Why and How 5-Session Adapted CPRT Works

Given the triangulation of positive changes in child and parent functioning and indications of the process of change in the parent-child dyads, and the strong retention of parents through to the completion of the therapy, the two main hypothetical foundations imposed in the 5-session module of adapted CPRT, as described in Chapter 4, were well supported. The first hypothesised process was that positive changes in parent and child behaviour could be attained in five sessions of adapted CPRT, if a dynamic interaction between (a) parents' implementation of strategies, (b) child's behavioural improvement and (c) the parents' retention took place in an ongoing and transactional manner, as illustrated in

Figure 30 (p. 140). The observation data convincingly showed that parents implemented the taught strategies subsequent to each intervention session. In the meantime, corresponding positive changes in targeted child behaviours were recorded by the parents across the intervention. In addition to the overall high parent retention, clinically significant changes were reported for all children's behavioural problems on ECBI following the intervention. The concurrent positive findings in these three variables are evidence that the hypothetical process and relationship between parents' implementation of strategies, the child's behavioural improvement and the parents' retention have taken place and ultimately produced clinically significant changes in child behaviour. The consistent improvement across the three variables was indicated as crucial in producing clinically significant change in child behaviour in as few as five intervention sessions.

In relation to the first hypothesised processes, three specific alterations to the original CPRT were proposed as fundamental to adapted CPRT. These pertained to the intervention's (a) duration, (b) contents, and (c) procedures. First, the duration of the intervention was reduced by half to increase parent retention. Second, the contents of the first five sessions of the original CPRT were identified as containing the key strategies related to intervention outcomes. Third, two home visits were incorporated, which consisted of a live demonstration of the child-centred play sessions with the targeted child by the intervention provider. The supervision of parent-child play sessions, were aimed to stimulate experiential learning by the parent to promote engagement and to enhance the possibility of positive intervention gains. Each of these contributions, duration, content and home visits, contributed to the strong findings of Study 2.

The first component was a reduction in the number of sessions. The 5-session module of adapted CPRT was less time demanding than the original CPRT, which requires a high commitment from families (Cornett & Bratton, 2013). Study 2's findings convincingly show

with a short intervention duration, adapted CPRT has avoided the common reason for putting parents off participation in parenting interventions (Heinrichs et al., 2005) and thus successfully retained seven out of eight parents in the programme. A common decreasing trend in parent attendance over the length of a parental programme (Baker et al., 2011; Topham & Wampler, 2008) was not found in Study 2, as the seven parents who completed the adapted CPRT attended all five sessions. Adding to that, adapted CPRT retained the potential intervention outcomes of the original 10-session CPRT on all parents and their children in just five sessions. Together, these findings support that the 5-session adapted CPRT is shorter and might be less expensive but that would have to be determined in future studies.

The second component was a focus on the most effective strategies. Evidence of the possible effectiveness of some taught strategies on positive changes in child behaviour was found in Study 2. While clinically significant changes in child behaviour were found in all children, improvements in particular taught strategies were observed across most parents. For instance, most parents showed a gradual improvement in using *reflective statements* and *behavioral descriptions*, while they continued to eliminate commands and information questions accordingly as they were taught. These suggest that using *behavioural descriptions* and *reflective statements* and eliminating commands and information questions might be the active variables that reduced child behavioural problems, and thus caused the overall reduction in parent-reports of child disruptive behaviour on ECBI. These findings are consistent with the concept of filial therapy on relationship enhancement, which suggests that parents' implementation of the basic play therapy strategies, which (a) allow the child to lead by not giving commands and not asking questions, and (b) accepting and being-with the child by reflecting their thoughts and feelings and describing their doings, are the active and

critical components in establishing a therapeutic parent-child relationship, which promotes therapeutic outcomes, such as a reduction in parent-reports of child behavioural problems.

However, one strategy was not as effective as hypothesised, as not all parents had opportunities to implement *A-C-T limit-setting*. Likewise, in a study of a 6-sessions CPRT, only one out of seven parents reported clinically significant change in child behaviour on ECBI after *A-C-T limit-setting* was taught (Moses, 2013). Together, these findings suggest that *A-C-T limit-setting* might not play a critical role in reducing child behavioural problems through parent-reports. However, the lack of opportunities to use *A-C-T limit-setting* after it was taught in Study 2 limits the conclusion of its impact in reducing child behavioural problems and thus additional evaluation and further studies are needed to clarify this.

The third component was the use of home visits for two of the five sessions. In terms of the additional home visits in adapted CPRT, which consist of a live demonstration of child-centred play sessions and supervision of parent-child play sessions, the observational data suggests possible contributions of both the home visit and the live demonstration. In particular, most of the parents increased in using *reflective statements* and *behavioural descriptions* and reduced in asking information questions and giving commands. Smith and Landreth (2003) suggested that live demonstrations were excellent for those who were able to attend, while it was helpful to use video-tapes for parents who were not able to attend the live demonstrations. Similarly, the benefit in observing the therapist demonstrating play therapy strategies with her child was reported by a mother as "the best way to learn it" in a qualitative study of FT (Foley et al., 2006, p. 48). Together with the results of Study 2, these suggest that the live demonstration of child-centred play sessions and possibly the supervision of parent-child play sessions at home could be a contributing factor in parents' gains in the taught strategies.

An additional aspect of the third component of home visits was the inclusion of demonstrations of child-centred play sessions. Parents' positive feedback on the demonstration of child-centred play sessions indicated its potential contribution to parents' engagement and retention. For instance, all parents who completed adapted CPRT highly valued the demonstrations of child-centred play sessions in helping them to increase their confidence with the concept and the strategies of child-centred play. In addition, most of the parents indicated that the demonstrations of child-centred play sessions were the most helpful part of the programme. For example, Parent 12 described them as *"…hands on with interacting in the playroom…watching how it should look*" and Parent 6 said *"I like the programme; I can actually see how it can work through the demo"*. While its role in enhancing parents' engagement and thus retention might be unclear, the parents' feedback regarding the demonstration of child-centred play sessions revealed the parents' interest and confidence in the intervention.

The inclusion of demonstrations of child-centred play sessions in the third component of home visits might also contribute to the promising findings of 5-session adapted CPRT in producing clinically significant changes in child behavioural problems across all children whose parents completed the intervention. Likewise, positive outcomes on child behavior was also reported in an intensive FT study (Smith & Landreth, 2003), which included live demonstrations of child-centred play sessions with target children. In that study, statistically significant decreases in externalising behaviour were found between the children in the experimental and non-treatment control groups. Adding on to that, most parents in Study 2 was found to improve in taught strategies following the demonstration of child-centred play sessions. Together, these suggest that a live demonstration of play sessions for each individual parent might be a contributing factor for the high number of children who made clinically significant gains in their behaviours as it increased parents' abilities to implement

the taught strategies, which produced the promising positive change in the children's behaviour.

A final aspect of the third component, home visits, was the inclusion of supervision of parent-child play sessions at the parents' homes. This is unique to Study 2, and has not been part of other filial therapy studies (e.g., Athanasiou & Gunning, 1999; Dillman Taylor et al., 2011; Grskovic & Goetze, 2008; Topham et al., 2011). Instead, these FT studies reported the use of various methods, presumably to help the parents transfer skills to their homes. For instance, Topham, Wampler, Titus and Rolling (2011) reported that the therapist spent three sessions teaching skill generalisation, while Grskovic and Goetze (2008) included at least two individual sessions for feedback on video-recorded play sessions with each mother in addition to six group discussion sessions. Dillman Taylor et al. (2011) had the group leaders model desirable strategies, while Athanasiou and Gunning (1999) used video demonstrations of play sessions and they both provided group supervision and feedback on video-recorded parent-child home play sessions over five to eight intervention sessions. In the light of the encouraging findings in Study 2, the in-home supervision might have successfully helped the parents learn how to conduct child-centred play sessions at home and consequently further strengthened the parents' abilities to generalise taught strategies at home and hence produce the high number of children who made gains.

The three components of the adapted CPRT have been shown to be associated with the positive results of Study 2, in line with the first hypothesised process. First, the reduction in the number of sessions in adapted CPRT did not compromise the potential intervention outcomes of the original 10-session CPRT but making it less time demanding than the original CPRT. Then, the observed increases in four of five most effective strategies taught in adapted CPRT were shown to be related to the parent-reported clinically significant changes in all children's behavioural problems. The home visits, which include the

demonstration and supervision of play sessions, were found to be an active component to engage parents in the intervention and thus help them learn and implement the taught strategies proficiently. The results in Study 2 justified the first hypothesised process by including the three specific components in the adapted CPRT to produce rapid improvements in parents and their children in a short time-frame.

The second hypothesised process underpinning the design of the adapted CPRT involved the necessity of parent experiences of deconstruction of their original attributions of their child's behavioural problems, and a reconstruction of these concepts, as proposed in Chapter 4 (Figure 31, p. 158). The results of the study which indicate positive changes in their perceptions and behaviours support the role of this hypothesis in bringing about the positive changes in parent and child behaviour. Due to that hypothesis, specific content was added to the CPRT. This included the procedure to establish a therapeutic relationship between parent and therapist and to use that as a basis to discuss the conceptualization of the child's behaviour, were designed to address negative parent attributions. Evidence as to changes in negative parent attribution of the child and the child's behaviour are relevant to consideration of the second hypothesised process.

Negative attributions of their children and their children's behaviours were expressed during intake meetings. Half of them perceived themselves as the victims of their children's behaviours and believed that their child intended to misbehave. For example, Parent 6 stated that Child 6 "*is manipulating and controlling me with his negative behaviour*". Similarly, Parent 7 and Parent 10 felt that they were targeted by their children and that their lives were controlled by their children. Other parents perceived themselves as unloved by their children. For example, Parent 5 and Parent 8 felt miserable that their children often said "*I hate you*" to them, while Parent 12 was disappointed that she could not gain her daughter's trust. Most of the parents indicated that being with their children was stressful and unenjoyable, thus they

avoided being with their children when possible. The parents' disclosures prior to the intervention suggested that they all perceived their children as the source of the problems and thus took a passive role in their relationships with them.

A shift in the parents' negative attributions about their children was disclosed in the first few intervention sessions. For instance, Parent 6 said, during Session 3 that "*I'm not doing the right thing towards his tantrums, I think and that makes me stressed…there must be something that I can do but I don't know what I should do*". Parent 5 admitted, in Session 2, that she "*asks too many questions and tends to over-explain thing" to her child,* which did not help with her son's misbehaviours. Both parents from Family 7 declared that they never thought about why their daughter behaved the way that she did and they also admitted that they had no strategies other than giving rewards and punishments. The parents' statements indicate that they began to deconstruct their negative perceptions of their children by exploring their roles in their children's behavioural problems and thus began to reconstruct new thoughts about themselves and their children. Likewise, in a phenomenological study of FT (Wickstrom, 2009), parents indicated that they achieved an increased understanding of their children and an improved parent-child relationships by altering their perceptions of their children. A group leader, in Dillman Taylor et al.'s study (2011), stated that positive change in parents' perceptions of their children was the most important area of growth in competency and parenting role for all parents following a 10-session module of CPRT. Together with the results of Study 2, these suggest that a positive shift in parents' perceptions toward their children is a crucial step for parents in attaining positive intervention gains.

A second indication as to the value of the deconstruction-and-reconstruction process was shown by positive changes in parents' attitudes and behaviours toward their children during the intervention were indicated through the parents' comments about the taught strategies. For example, Parent 6 specified that she was able to reflect (a reconstruction)

rather than to dismiss or deny (a deconstruction of her former beliefs) the child's feelings, which helped her to understand her son's true feelings. She reported that she feels good using the child-centred play strategies as they "*are very subtle but very powerful*". Similarly, Parent 5 reported that she reduced asking questions and indicated that reflective response "*is working with (her son)*". Parent 8 stated that the taught strategies not only worked for her child but helped her to engage with her child, which she was never willing to do before. Parent 11 disclosed that her son's positive response toward the strategies made her realise that she had not been giving him enough attention. Parent 12, on the other hand, indicated that using reflection was "*awkward*" for her to "*just repeat what (the child) said*". She also indicated that it was very hard for her to "*force*" herself to stop asking questions or not to "*teach*" the child. Parents' disclosures suggest that adapted CPRT has successfully helped the parents to deconstruct their negative attribution about their children in early sessions and consequently reconstruct it into a more positive one through learning the new knowledge of child behaviour problems and the CCPT strategies. The constructive changes in the parents indicate that the therapeutic relationship between the therapist and the parents has taken place, as hypothesised.

A third indication regarding the deconstruction-and-reconstruction process was shown by parents' understanding and acceptance of the taught principles and strategies were revealed in some of their statements in the late intervention sessions. For example, Parent 6 said "*I need to put away my negative thoughts about (the child)…he is manipulating me…he is controlling me with his negative behaviour*". She explained that her negative thoughts and feelings about her son were making her emotionally shut down from him and thus she was unable to focus and be aware of her son's feelings and wishes. She admitted that she needed to change in order to help her son engage in positive behaviour. Parent 11 said that she did not like the teachers who restricted her son's play and insisted on his using specific things

only for specific purposes, which she used to agree with. Parent 5 indicated that the taught strategies were "*so simple but valuable*", which helped her eliminate long explanations, and because of that she felt good about herself as she knew how to respond to her son's tantrums. Parent 8 said that she was pleased that she had made a difference in her relationship with her son, as her son did not say "*I hate you*" for two weeks, while he could reflect her feelings, particularly when she was sad and quiet. The parents' expressions stated above indicated that they had reconstructed their negative attribution about their children, which behavioural problems are intentional, into a more positive one by demonstrating constructive changes in their attitudes and behaviour toward the child, which was consistent with second hypothesised process in adapted CPRT.

The Exception to the Overall Improvement in Parent and Child

The importance of the role of the second foundational process can be seen in the failure of one parent-child dyad to show sustained improvement. The one exception to this overall pattern of improvement of parenting behaviour concurrent with improvement in child affect, behaviour and self-concept was Family 10. Parent 10 did not show improvement in *reflective statements* in parent-child play sessions during the intervention phase, except Session 3 and she did not maintain her gain in giving *esteem-building* responses at post-intervention and Follow-up 2. Child 10 displayed an inconsistent trend in *child questions parent* and *child commands* to parent throughout the course of the study. In contrast with other children, targeted positive behaviour either deteriorated across the course of the study or returned to its baseline levels at Follow-up 2 and he rated himself lower in positive self-concept after the intervention.

The difficulty of Parent 10 in learning all strategies and the lack of corresponding change in Child 10's behaviour can be interpreted according to Rogers' (1942) assumptions. It might be that Parent10 had difficulty to learn and "assimilate'' the strategies and thus was

not able to execute them as "a system of attitudes" (Rogers, 1949, p. 82), when interacting with Child 10. Parent 10's previously held beliefs may not have been thoroughly deconstructed. For example, Parent 10 was not able to consistently use reflective statements or esteem-building as observed in the videos. This suggested that Parent 10 was finding it difficult to persist with using the whole set of taught strategies. As hypothesised by Rogers, by using a few taught strategies at any one time, Parent 10 might have insufficiently conveyed the empathy in a cohesive manner to her child. As a consequence, a therapeutic relationship was less likely to be established between the parent and child and this is postulated as a requirement for constructive change. Thus, this might explain why there was little effect on Child 10's behaviour.

Consistent with person-centred principles, the effectiveness of adapted CPRT on a parent relies on the attitudinal orientation of the therapist. The parent's experience with the therapist is a decisive constituent in understanding person-centred principles and strategies and thus integrating them into the parent's values system and being part of his or her attitudes. Therefore, other than continuous reflection of self-effectiveness during the therapy, it is important for the therapist to remember that the parent is, in fact, the centre of the intervention not the child. The therapist needs to identify and respect the parent's incongruity and difficulty in any aspects and levels of self during the intervention and be eager to promote changes in the parent. However, a parent's awareness cannot be imposed but stimulated by the consistent genuine acceptance of a therapist of the parent's current state of personality organization and continuous trust of the therapist in the parent's ability to achieve self-awareness and self-constructiveness (Rogers, 1949).

A possible resolution for this shortcoming is to have additional demonstrations of child-centred play sessions or to have additional activities that might strengthen the therapist-parent relationship. It is expected to provide more opportunities for parents to observe how the

fundamental set of person-centred attitudes is executed through related strategies to their children and how their children respond to the strategies. This might be harder to achieve through abstract discussion and revision of the theoretical principles of the intervention as they were used in Study 2. During demonstrations, parents are likely to achieve experiential learning as an observer as well as an outsider and thus make more objective judgment of the philosophy of the person-centred approach embedded in child-centred play sessions. Taking into account the difference in the individual parent-child dyad, the number of child-centred play demonstrations in adapted CPRT could be increased accordingly to support particular parents to achieve promising gains in respect to their own capacities. As a parent's philosophical orientation of self and others is fluid toward constructiveness (Rogers, 1949), demonstration of child-centred play sessions could support parents to deconstruct their negative attributions and reconstruct their belief systems into a positive form, which is congruent with the attitudes and strategies taught in adapted CPRT.

Limitations

Despite the encouraging findings, several limitations, in terms of methodology, were identified in Study 2. The findings of Study 2 need to be interpreted with the following limitations. First, the single-subject design chosen has its limitations, such as threats to internal and external validity. In terms of internal validity, a varied length of seven to 14 days baseline period of the children's targeted behaviours was used in Study 2 instead of achieving stability of the behaviours (Cooper et al., 2007). While not many, some children's targeted behaviours did show in the trend of the desired direction during baseline. However, the weakness of the predetermined baseline was strengthened by using a multiple-baseline across participant design to increase the controlling effects of the intervention (Barlow & Hersen, 1984). A varied period of baseline of child behaviours across participants has been used in other studies involving parents to study the intervention effect. For instance, a study

of the effectiveness of IY-PT has a 4- to 24-day baseline interval, in which stability of the targeted child behaviours was not attained in some cases (Lees & Ronan, 2008). Nevertheless, not waiting until a stable trend was established is indeed a limitation. Future studies should be sure to establish a stable baseline if possible.

In terms of external validity, single-subject designs reply on successive replications of desired changes across participants to demonstrate support for the changes resulting from the intervention (Kazdin, 2003). The findings in Study 2 showed that improvements in parent and child behaviours were replicated across all participants, with the exception of one or two child behaviours. Similarly, replication of preferred changes of child behaviours across participants was demonstrated in a single-subject study of play therapy across two children (Swan & Ray, 2014), while in a multiple baseline single-subject study of a parent training intervention, replication of preferred changes was demonstrated in some targeted child behaviours (Lees & Ronan, 2008). Thus, the replication was not completely established for all behaviours of parents and children, which weakens the overall strength of the results.

A second limitation was that the part of the data collection procedure, especially the weekly parent-child play observations, might itself contribute to the overall positive effect of adapted CPRT on parents and their children. While adapted CPRT required the parents to conduct at least four parent-child play sessions during the intervention, seven additional parent-child play sessions were required to be carried out by the parent as part of the research protocol and method for data collection. The overall outcomes of Study 2 on the parents and their children were more likely to reflect the cumulative effect of all the play sessions, both within the scheduled CPRT and the scheduled video-observations, as it is impossible to isolate the effect of either on the parents and their children. Combining research and therapy always will have the possibility of conflating the results of therapy in different ways than when therapy is conducted without a research component. Thus, Study 2 is limited in that the

contribution of the video-taping of the child-parent sessions for measurement purposes may have confounded the results.

Another limitation related to the data collection procedure was that all intervention sessions and assessments were conducted and administrated solely by the researcher, which may have influenced parents' responses. For example, the parents might not feel free to express their negative views of the intervention, if any, during the parent feedback interview. The findings would have been more convincing if the interviews were conducted by an individual other than the researcher who was without any specific knowledge about the intervention and the study. Equally, they might have been less likely to express their negative views of the intervention, because the parent might not trust the other person as much. Either ways, it points to the essential of obtaining reliability of coding, which was clearly lacking in Study 2, and thus need to be addressed in future studies.

The objectivity of the coding process on the observational data is another important limitation. In Study 2, independent observers, other than the researcher, and who did not deliver the intervention, were not used for coding all parent-child play sessions using the *Dyadic Parent-Child Interaction Coding System* (DPICS). While the researcher attempted to follow the ethical and professional standards, the objectivity of the coding might not be fully maintained. This limits the reliability of the findings; therefore caution is warranted in interpreting the results from this coding. To address this limitation, future studies should employ independent observers.

Moreover, the length of follow-ups, 6- and 12-week, used in Study 2 was rather short, thus limiting the ability to determine the longer-term maintenance of intervention gains. Adding to that, incomplete follow-up data were provided by some participants. For example, one of the seven families did not complete the 6-week follow-up assessment and declined to provide any data at the 12-week follow-up, while another family only provided partial data at

the 12-week follow-up. Although this has been reported in other research studies (e.g., Moses, 2013), these incomplete data are likely to weaken the certainty of the maintenance effect of adapted CPRT.

Some of the measures may also have limited the study. The current study extended previous filial therapy studies by utilising a standardised observational measure. As a behavioural oriented measure, the *Dyadic Parent-Child Interaction Coding System* (DPICS) (Eyberg, Bessmer, Newcomb, Edwards, & Robinson, 1994) was modified in Study 2 to measure parent skill acquisition and specific child behaviours. For instance, the Parent-Led and Clean-Up sessions were not included in Study 2, as the parents were taught not to give commands to their children during play sessions. On the other hand, additional parent responses taught in adapted CPRT were coded, which include *A-C-T limit-setting*, *esteem-building*, *positive choices* and *choices as consequences*. The definition of reflective statements in the original DPICS was redefined in Study 2 to match with the reflection strategy taught in adapted CPRT, which includes reflection of verbal statements and reflection of feelings. These changes limit direct comparison between the current study and previous studies, which used the original DPICS. In addition, there is no reliability on the coding. Thus, results determined from this coding must be very cautiously interpreted. This limits the study findings.

The *Parent Behaviour Diary* (Appendix I) in the form of tally sheets was established and used by the parents to record their child's targeted behaviour in the Study 2 from baseline up until two weeks after the conclusion of the intervention and again for another two weeks at Follow-up 2. While it is not a standardised measure, it is one of the major measures in Study 2. Parent diary has been commonly used in behavioural parent-intervention studies, which employed single-subject designs, as a measure to monitor behavioural changes in children (e.g., Lees & Ronan, 2008) along with other standardised outcome measures of child

behaviour, as it was used in the Study 2. The behaviour parent diary might limit the results of Study 2, as it was used by parents to record targeted child behaviours without monitoring. Therefore, the reliability and accuracy of the data could not be determined. As a result, parents might have over or under reported of positive or negative child behaviour. For example, Parent 6, in Session 3, admitted that if she was very angry when Child 3 did not compliance with her instructions, she would report two or three incidents of child non-compliance on the tally sheet, even the child only showed one incident of non-compliance at that time. Therefore, Study 2's results must be interpreted with great caution.

Having the therapy only attempted by one therapist is another important limitation. The 5-session adapted CPRT would not be useful until it has been researched by many more therapists. Therefore, future studies with varied research designs and methods, such as randomised controlled-outcome and qualitative methods, are needed in addition to single-subjects designs to further investigate the 5-session adapted CPRT and determine its outcomes as well as important information regarding the intervention process. Ideally, all the limitations of Study 2, in terms of research designs and methodologies, as identified above should be sure to address in future studies, in order to provide strong evidence that positive outcomes in parent and child are resulted from the intervention.

The group model of intervention is a significant characteristic of CPRT. The process of a group and its effects on the intervention is emphasised in the manual (Bratton et al., 2006). However, both the 10-session CPRT, in Study 1, and the 5-session adapted CPRT, in Study 2, were administrated in an individual format. The review of CPRT research on child behavioural problems in Chapter 2 (as summarised in Table 2, p 49) indicated that three out of five studies administrated CPRT in an individual format and positive intervention outcomes were found. Similarly, positive outcomes in the parents and their children were found in Studies 1 and 2, however these studies are limited to an individual format of CPRT.

The parents in Studies 1 and 2 did not experience the group process; therefore the impact of group as well as the elimination of group is not able to be determined. While the CPRT research indicated that both individual and group formats of CPRT were effective on child behavioural problems, more studies are needed to identify the differences in intervention effects, if any, between group and individual administration of CPRT or filial therapy.

Implications and Recommendations

Implications for practice. The findings of Study 2 are preliminary support for the 5-session adapted CPRT, which includes two home visits. The new manual of the adapted CPRT could be important for practitioners who are keen to understand and consider alternative approaches to address child behavioural problems. It could guide mental health practitioners to make more informed choices when working with families of children with significant behavioural problems. Based on the promising findings of the 5-session adapted CPRT in producing clinically significant changes in child disruptive behaviour in five intervention sessions, mental health practitioners could consider it as a prospective intervention for parents of children with clinical levels of behavioural problems, especially for those parents who are looking for a short-term intervention due to time constraints or schedule conflict. Because adapted CPRT is conducted in an individual format within a short duration and has retained the potential effectiveness of the original CPRT, it is likely to reach those parents who need help and assistance for their children's behavioural problems, but do not have sufficient time to participate in an intervention, which delivers in a longer timeframe with a fixed schedule.

The benefits of home visits, particularly the inclusion of demonstration and supervision of play sessions on parents' skill acquisition and overall in parents and their children, as indicated in Study 2, provide useful information for mental health practitioners. For example, when delivering play interventions, mental health practitioners could consider including

home visits for play session demonstration and supervision into their clinical practice, in order to enhance intervention gains in a limited time-frame. Contact hours of practitioners' are always highly demanded in clinical practice, therefore approaches or procedures that could promote promising gains in clients, while requiring a short amount of time from a practitioner, are highly regarded in clinical practice. However, it may be necessary to include additional video sessions, which were used in Study 2 as part of the continuous measure, to assist both parents and therapists to reflect and plan, as it is unclear that the effects can be achieved without these additional feedback sessions. As for parents, allocating home visits into a short intervention make it family-friendly. The 5-session adapted CPRT could eventually prove to be a valuable addition to the typical range of available services.

The basic CCPT strategies taught in adapted CPRT were shown to be the most effective strategies in producing clinically significant changes in child behavioural problems, if parents successfully learned and implemented them accordingly in parent-child play sessions. This information together with the successful experience of most parents in deconstructing and reconstructing their misperceptions about their children, are important for practitioners as there are useful examples to be replicated by practitioners and parents to produce promising intervention gains.

Implications for future research. Establishing the usefulness of the programme for the population of interest is critically important for intervention development. While promising outcomes for the adapted CPRT in terms of parents and their children in Study 2, future studies of the 5-session adapted CPRT should overcome all of the limitations of Study 2. Improvements, in terms of research methods, are suggested to be employed in future studies of the programme to increase the certainty of parent and child outcomes as being related to the intervention. First, it is recommended that when single-subject designs are employed, the baseline phase should be extended to achieve stability of targeted child

behaviours. Thus, positive outcomes could be convincingly interpreted as a result of the intervention.

Second, intervention fidelity needs to be obtained by having at least 25% of the recorded intervention sessions randomly selected to be rated according to a list of standard procedures and contents of the intervention by an individual who is familiar with the programme, but not directly involved in the studies. Third, it is advisable that future studies employ different individuals for intervention implementation, outcomes assessment and data analysis. Fourth, to address the limitation of the undetermined reliability and accuracy of the data from the *parent behaviour diary*, L. Keown (personal communication, October 28, 2016) suggested that a small number of families could be randomly selected to have both parents independently record the same targeted behaviours of their child over the same period of time as a reliability test in future studies. In addition, father and mother's audio-recording data might be obtained to capture child behaviours as indicated in a study (Goldstein et al., 2007). For instance, in that study, the authors got mothers and fathers to each make 2-hour recordings of interactions with their child at times that were likely to be stressful for them to code parenting behaviours. The above procedures are to reduce potential biases in providing data by respondents and biases in interpreting data and thus increase the overall reliability of the findings.

Fifth, some specific measure should be included in future studies of adapted CPRT. For instance, related outcome measures, such as *Parents' Attributions for Child Behavior Measure,* should be included as an outcome measure to assess the changes in parents after attending adapted CPRT, which emphasises addressing parents' negative attribution for child behavioural problems. Addressing negative parent attribution is a newly invented and important component in the 5-session adapted CPRT; however it has not been fully measured using a standardised measure in Study 2. While parents' disclosure is important in revealing

their changes in perceptions, findings from standardised measures would further validate its role as a potential mechanism for intervention gains and thus extend our understanding regarding the variable.

The *Joseph Picture Self-Concept Scale* (Joseph, 2004) used in Study 2 should also be included in future study of filial therapy and adapted CPRT, as it is relevant to the theoretical underpinnings of FT. The main importance of having a measure of self-concept in Study 2 is due to the crucial role that child self-concept plays in the therapy. However, it has not been widely used in FT studies or other parent-intervention studies. To date, only a few FT studies have used the older version of JPSCS, known as the JCSC (e.g., Costas & Landreth, 1999; Landreth & Lobaugh, 1998; Smith & Landreth, 2003), as an outcome measure. In terms of theoretical underpinnings of FT, improvement in child positive self-concept is perceived as an important indication of intervention success, as hypothesised by Rogers (1951).

The *Parent-Child Dysfunctional Interaction subscale* of the PSI-SF (Abidin, 1983) is another important outcome measure to be included in future FT studies. This measure is significant to FT, specially the items in the *Parent-Child Dysfunctional Interaction* subscale, as they are relevant to the content of FT as well as the adapted model of CPRT. The PSI-SF (Appendix H, p.376) was widely used as an outcome measure to determine changes in stress related to parenting after the completion of a parenting programme, including CPRT, PCIT and IY-PT (e.g., Borrego & Burrell, 2010; Lees & Ronan, 2008; Lindo et al., 2012). Therefore, this measure is highly recommended to determine reductions in parenting stress as an intervention outcome.

Sixth, further studies should include long-term follow-up assessment for at least 12 months following the intervention. Given that the 5-session adapted CPRT is a relatively short intervention compared to other parent or parent-child interventions, which aim to address the highly persistent child behavioural problems, determining the long-term

maintenance effect of the programme on the population of interest is crucial. While Study 2 has demonstrated that intervention gains in the parents and children have been maintained up to three months following the conclusion of adapted CPRT, information regarding its long-term effectiveness is rather important in establishing the programme and its efficacy.

In addition, important contributions can be made by qualitative studies. For example, some qualitative studies of FT or CPRT have provided some useful information about the intervention. For example, Wickstrom (2009) studied parents' experiences in FT through a phenomenological study and discovered that in addition to an improved parent-child relationship, FT improved marital relationships and family relationships as a unit. Chen, Higdon and White (2006) discovered important factors that contributing to the decreased parenting stress following FT. Moreover, parents' evaluation of the intervention has identified the most useful and the most challenging FT strategies for them to implement with their children. These findings provide significant implications for clinical practice. Therefore, qualitative studies of adapted CPRT would help reveal valuable information about the adapted CPRT.

Similarly, contributions can be made by large scale quantitative studies, once its efficacy is established using methodologically sound designs. Replication of the promising outcomes of the programme with the population of interest in future studies is crucial in establishing its efficacy. Therefore, the next step for future researchers is to evaluate the generalizability of its effectiveness using randomised-controlled trials (RCTs) with a larger sample size (e.g., Bor et al., 2002; Bratton et al., 2013; Sanders et al., 2000). For example, the effectiveness of 5-session adapted CPRT could be tested by comparing it to a wait-list control group, an alternative intervention or a treatment as usual in a control group with a broadly representative sample of parents of children with significant behavioural problems across different settings. These studies would provide good information about the adapted

CPRT, as sufficient and consistent findings revealed from a series of RCTs on its effectiveness would help to establish the programme as evidence-based.

Conclusion

The present study has successfully employed multiple-baseline single-subject research designs to provide a positive indicator of the potential of the adapted 5-session CPRT. All children obtained clinically significant changes in their behaviours on a widely-accepted standardised parent-measure. The findings provide initial evidence of the possible effectiveness of the programme through the parents' and the children's observed behaviours, including increases in positive parenting skills related to child-centred play strategies and child self-directive behaviour, during parent-child play sessions. Reductions in parent-report and parent-record of child behaviour problems and parent-report of parental stress were found in all seven families of young children with behavioural problems following the intervention. Improved child-report of self-concept was reported by six out of seven children. The results support the two main hypothetical processes imposed in adapted CPRT, which advocate the potential components which may contribute to substantial gains in parent-child dyads in just five intervention sessions, which include the fundamental child-centred play strategies, home visits for demonstrations and supervision of child-centred play sessions, as well as the specific contents and procedures to deconstruct-and-reconstruct parents' misperceptions of their children. Overall, Study 2 has documented how an experiential learning platform could be established for parents to learn the strategies and principles taught in the adapted CPRT as well as to help them deconstruct-and-reconstruct their negative perceptions about their children, in order to produce promising gains in them and their children in as few as five intervention sessions. The preliminary findings for the adapted CPRT point to the need for future studies using methodologically sound designs, including single-subject designs, qualitative methodologies and group randomised-controlled designs. In sum, given the

emphasis on parent-child relationships as the aetiological factor of child behavioural problems, constructive changes in parents' attitudes toward and perceptions about their children were achieved by the 5-session adapted CPRT. This is different to mainstream behavioural parent training intervention, and may serve as a useful alternative approach for child behavioural problems.

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Appendices

Appendix A1: Human Ethics Approval for Study 1

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2011/05

8 April 2011

Yin-Yin Loh
Health Sciences Centre
UNIVERSITY OF CANTERBURY

Dear Yin-Yin

The Human Ethics Committee advises that your research proposal "Filial therapy and behaviourly family intervention with families coping with children's behavioural problems" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 30 March 2011.

Best wishes for your project.

Yours sincerely

pp LGriffioen

Dr Michael Grimshaw
Chair, Human Ethics Committee

Appendix A2: Human Ethics Approval for Study 2

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/125

16 October 2013

Yin Yin Loh
Department of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Yin Yin

The Human Ethics Committee advises that your research proposal "Helping your child through plan: filian therapy with families coping with chidlren's behavioural problems" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 7 October 2013.

Best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix B1: Consent Form-Study 1

Health Sciences Centre

Tel: +64 3 366 7001, ext: 3694, Fax: + 64 3 364 3318
Email: yyl34@canterbury.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

CONSENT FORM

Help for Families Coping with Behaviour Problems

I/we have read and understood the description of the Family Programme above. On this basis I/we agree to participate in the project.

I/we give my/our consent to my/our child's teacher to provided information regarding my/our child's behaviour and self-control by completing the two questionnaires: (i) Strengths and Difficulties Questionnaire (SDQ) and (ii) The Self-Control Rating Scale (SCRS).

I/We understand that all information supplied during the course of this research is confidential unless the researcher is concerned about someone's safety. In this case I/we understand that information may need to be supplied to appropriate agencies.

I/we consent to publication of the results of the project in academic journals and presentation at conferences and disseminated to community groups for educational purposes with the understanding that anonymity will be preserved.

I/we understand that participation is voluntary and my/our child and I/we may choose to withdraw at any time from the project, including withdrawal of any information I/we have provided.

I note that the project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

My signature indicates that (1) I have read the information in the attached letter; (2) I have decided to participate, with my child.

_____
Name of Child

_____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian Date

_____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian Date

_____
Signature of Researcher Date

Appendix B2: Consent Form for Study 2

Health Sciences Centre

Tel: +64 3 366 7001, ext: 3694, Fax: + 64 3 364 3318
Email: yin.loh@pg.canterbury.ac.nz or vyen79@gmail.com

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

CONSENT FORM

Helping Your Child through Play

I/we have been given a full explanation of this project and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in the research.

I understand that participation is voluntary and I and my child may withdraw at any time without penalty. Withdrawal of participation will also include withdrawal of any information I have provided should this remain practically achievable.

I/we consent to publication of the results of the project in academic journals and presentation at conferences and disseminated to community groups for educational purposes with the understanding that anonymity will be preserved.

I understand that any information or opinions I provide will be kept confidential to the researcher and her supervisors, and that any published or reported results will not identify the participants. I understand that a thesis is a public comment and will be available through the UC Library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after ten years.

I understand that I will receive a report on the findings of the study, after the PhD has been completed.

I understand that I can contact the researcher or her supervisors for further information

Vanessa (Yin-Yin Loh) <yin.loh@pg.canterbury.ac.nz> 021-2125-381

Associate Professor Kathleen Liberty, <kathleen.liberty@canterbury.ac.nz> 027-349-0645

Associate Professor Karyn Gail France <karyn.france@canterbury.ac.nz>

If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz),

By signing below, I agree to myself and my child participating in this research project.

_____
Name of Child

_____
Printed Name of Parent or Legal Guardian Date

_____
Signature of Parent or Legal Guardian Date

Appendix B3: Confidentiality Contract

Health Sciences Centre

Tel: +64 3 366 7001, ext: 3694, Fax: + 64 3 364 3318
Email: yyl34@canterbury.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

CONFIDENTIALITY CONTRACT

Help for Families Coping with Behaviour Problems

I understand that the above Family Programme is a UC PhD research project. On this basis I agree to be involved as an additional coder for the purpose of inter-rater reliability assessment.

I understand that all information supplied by the participants and researcher, in any form, during the course of this research is confidential unless the researcher is concerned about someone's safety.

I note that the project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

My signature indicates that (1) I have agreed to be involved in this project as an additional coder and (2) I will keep the research data confidential.

_____

Signature of additional coder Date

_____

Printed Name of additional coder Date

_____

Signature of Researcher Date

Appendix C1: Parent Information Sheet for Study 1

Health Sciences Centre

Tel: +64 3 366 7001, ext: 3694, Fax: + 64 3 364 3318
Email: yyl34@canterbury.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

INFORMATION SHEET

University of Canterbury Doctor of Philosophy research project

Help for Families Coping with Behavioural Problems

The project
This is a University of Canterbury Doctor of Philosophy research project. You and your child are invited to participate in a family support programme 'Help for families coping with behavioural problems' at the Health Sciences Centre of the University of Canterbury. This programme aims to provide additional support for families by enhancing parenting strategies, in order to address behavioural difficulties among kindergarten children.

In this program we will compare two well-established programmes (Filial Therapy and Level-4 Triple P) by looking at their effectiveness with parents' and children's behaviours as well as your experience of using them. We are interested in:

(1) reducing child's problem behaviours,
(2) improving child's self-concept,
(3) increasing child's self-control,
(4) strengthening parenting skills, And
(5) consumer satisfaction

Who is the researcher?
This programme will be carried out by Vanessa (Yin-Yin Loh) who is a counsellor and counselling supervisor with more than 5 years clinical experience with children and families who experience behavioural and emotional problems. She has also received prior training in play, filial therapy, and Triple P. In addition, Vanessa is a PhD candidate at the Health Sciences Centre at the University of Canterbury under the supervision of Dr. Karyn Gail France, Registered Clinical Psychologist, Senior Lecturer and Child and Family Psychology Programme Co-ordinator.

What will I need to do?
If you choose to participate, you will be contacted through an initial telephone interview to ensure that you and your child meet the eligibility criteria.

Consequently, the eligible families will be randomly assigned to participate in either one of the family support programmes:

1) Ten 60-minute individual sessions of a non-directive play-based parent-child relationship enhancement programme (Landreth's Filial Therapy/CPRT) and five 30 minutes play (home play) sessions with your target child along the programme;
2) Ten 60-minute individual sessions of positive parenting programme (Standard Level-4 Triple P), which consists of seven clinic visits and three home visits.

If you choose to participate, you will also be asked to:

1) Complete four questionnaires which will require approximate 20-30 minutes, at three specific intervals: before the intervention begins, immediately after the intervention, and at 6-months after the intervention.
2) Keep a daily record of your child's behaviour by using a behavioural chart which will take less than a few minutes each day.
3) Come into our university clinic and allow us to video you and your child playing together, on three occasions over the same period.
4) During the visit allow us to spend some time with your child using the Joseph Picture Self-Concept Scale. This involves a 10-minute structured interview, which you will be welcome to watch though a one way mirror.
5) Complete a consumer satisfaction questionnaire which takes approximately 5 minutes, at the last session of the intervention.
6) Consent on behalf of your child's teacher to provide information regarding your child's behaviour and self-control by completing two questionnaires in each interval: (i) Strengths and Difficulties Questionnaire (SDQ) and (ii) The Self-Control Rating Scale (SCRS).

Your Benefits and Tasks
We are targeting children with moderate needs who often are not able to access services in the public system. You will receive a well-established intervention delivered by a qualified and experienced therapist. We do ask you to collect records and be available for negotiated appointments, especially for the intervention sessions. Outside of getting to appointments there will be no further cost to you. There is no personal risk directly involved with this study; however, there may be some discomfort or interruption in daily living by adopting new skills and tasks according to the above interventions.

What if we don't want the programme we are assigned to?
This kind of research does depend on participants receiving a randomly assigned procedure. However, you will be giving an opportunity to participate in your chosen/preferred intervention free of charge after your programme is completed, if you desire.

Confidentiality
The results of the PhD research project will be published as a public document via the UC library database and may be reported at international conferences and academic journals, but you and your child's identities will not be disclosed in any publication or discussion of this material. The information you and your child provide will be kept confidential. Information obtained from the questionnaires, behavioural charts and video recorder parent-child interaction sessions will be recorded with a coding system. Only the researcher of this

project will have a list of the participants' names. All participants will receive a report on the study.

The only exception to this confidentiality is if the researcher or her supervisor (Dr France) has concerns about someone's safety. In this case all steps will be taken to talk to you about the situation prior to information being divulged to appropriate agencies.

You and your child's participation are completely voluntary. You and/or your child have the right to withdraw from the project at any time, including withdrawal of any information provided without penalty or prejudice. Your decision whether or not to participate will in no way affect your child's standing in his or her classroom. At the conclusion of the study, a summary of results will be made available to all interested parents.

This project is being carried out as a PhD research study by Vanessa (Yin-Yin, Loh) (+64 366 7001 ext: 3694) at the University of Canterbury under the supervision of Dr. Karyn Gail France, Registered Clinical Psychologist, Senior Lecturer and Child and Family Psychology Programme Co-ordinator, who can be contacted at +64 3 3642610. They will be pleased to discuss any concerns you may have about participation in this project.

The project has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Appendix C2: Parent Information Sheet for Study 2

Health Sciences Centre

Email: yin.loh@pg.canterbury.ac.nz or vyen79@gmail.com

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

INFORMATION SHEET (FACE-TO-FACE MEETING)

University of Canterbury Doctor of Philosophy Research Project

Helping Your Child through Play

The project
This is a University of Canterbury Doctor of Philosophy research project. You and your child are invited to participate in a play-based family support programme 'Helping your child through play' at the School of Health Sciences of the University of Canterbury. This programme aims to provide additional support for families by enhancing parenting strategies, in order to address behavioural difficulties among young children.

In this program I am studying the outcomes of a model of play-based therapy by looking at its effectiveness with parents and children. The study aims are to:

(1) Reduce the child's problem behaviours,
(2) Improve the child's self-concept,
(3) Strengthen the parents ability to cope with child behaviour and/or emotional issues, and
(4) Reduce parental stress associated with child behaviour issues.

Who is the researcher?
This programme will be carried out by Vanessa (Yin-Yin Loh) who is a counsellor and counselling supervisor with about 10 years clinical experience with children and families who experience behavioural and emotional problems. She has also received prior training in play, filial therapy, and Triple P.

Vanessa is a PhD candidate at the School of Health Sciences at the University of Canterbury under the supervision of Associate Professor Kathleen Liberty, Early Intervention programme Co-ordinator and Associate Professor Karyn Gail France, Registered Clinical Psychologist and Child and Family Psychology Programme Co-ordinator.

What will be involved?
You, your partner and /or a support person, and your child are invited to participate in the following activities:

- One-two weeks of information gathering (explained below).
- Two individual education sessions at the Health Sciences clinic, one per week, about 60 to 80 minutes each, plus some homework (about 30 minutes per week)
- Seven individual play sessions with you and your child, once per week for 7 weeks, about 20-30 minutes. Five at the Health Sciences clinic and two at your home.
- You will be asked to play with your child for one 30-minute play session per week for throughout the intervention period weeks, for 5 weeks (and write down what happened).
- Two weeks of information gathering (to see if the changes maintain)
- A booster session, if needed
- A follow-up session

The information you will be asked to provide

1) Some information about you and your child: family background (about 10 minutes).
2) Complete two questionnaires about child behaviour and parent stress (10-20 minutes, before and after the study, and at follow-up)
3) Permit the researcher to interview your child about their sense of self. You can observe this if you wish (10 minutes, before and after the study, and at follow-up).

4) Allow the researcher to video-record you and your child playing together for about 20 minutes (once before the intervention, after each weekly intervention session, and once at follow-up). You will be able to see the videos, which will be used to help you and your child.

5) Keep a daily record of your child's behaviour on a form that the researcher will give you, which will take less than a few minutes each day during the course of the study.
6) Share your views and experiences about the programme through an interview conducted by the researcher within a week after the completion of the parent training programme, which takes approximately 20-30 minutes.

Potential benefits
You will receive a play-based programme delivered by the researcher. Previous studies indicate that this approach can be helpful to children and parents.

Right to withdraw
You and your child's participation are completely voluntary. You and/or your child have the right to withdraw from the project at any time, including withdrawal of any information provided without penalty or prejudice.

Confidentiality
All of the information collected will be confidential. In writing up the results of the study, only made-up names will be used. The video-tapes will not be included in my thesis, nor will there be any photos from the videos. All of the checklists, and other records, will be summarised.

Only the researcher of this project and her supervisors will have a list of the participants' names and be able to see the information collected. All the information will be stored in a locked filing cabinet in a locked office. Coded data will be stored separately on a computer that is password protected. The data linking the participant to the coded computer files will be destroyed ten years after the Ph.D. is complete.

The results of the PhD research project will be published as a public document via the UC library database and may be reported at international conferences and academic journals, but you and your child's identities will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires, behavioural charts and video recorder parent-child interaction sessions will be recorded with a coding system.

All participants will receive a report on the study.

You can contact the researcher or her supervisors if you have any questions or concerns.
Vanessa (Yin-Yin, Loh) <yin.loh@pg.canterbury.ac.nz> 021-2125-381
Associate Professor Kathleen Liberty, <kathleen.liberty@canterbury.ac.nz> 027-349-0645
Associate Professor Karyn Gail France <karyn.france@canterbury.ac.nz>

The project has been reviewed and approved by the University of Canterbury Human Ethics Committee. Participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in the study, you are asked to complete the consent form, and phone the researcher, who will arrange to meet with you to start the study.

[signature] Vanessa Loh

Appendix D: Recruitment Notices for School Newsletters

Recruitment Notice (Study 1)

UC UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

kidsfirst kindergartens

Parenting Can Be Very Challenging

Are you a parent of a child aged 3 to school age?

Do you...

- have difficulty getting your child to follow instructions?
- feel frustrated with your child's responses to your requests?
- have to work hard at mealtimes, bath times, and bedtimes?

*Talk to us - you may be eligible for a **free** parenting programme at the University of Canterbury*

For full information contact Anne on 364-2987 ext 4156
or email HSCClinic@canterbury.ac.nz

Sponsored by UC and Kidsfirst Kindergartens - a joint project for 2011-2012

Recruitment Notice (Study 2)

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

"Helping Your Child through Play"

Are you a parent of a child ages 3-6 years old?

Does your child have behaviour or emotional problems?

Would you like to learn more?

If you answered **"YES"** to the above questions,

You may be eligible for **A Free Parent-Child Intervention**
as part of a PhD research project

For further detail, please contact **Vanessa on 366-7001, ext: 3694.**

Email: yin.loh@pg.canterbury.ac.nz or vyen79@gmail.com

Appendix E: Intake Interview

Structured Intake Interview (Study 1)

Date of Interview :_____
Person(s) Interviewed and relationship to child
:_____

Child Identification
Child's Name : _____
Child's Sex : ( ) Male ( ) Female
Date of Birth : _____day_____Month_____Year

Reason for Referral:
Referral source: _____

List major problems/reasons for referral, in parents' own words/terms
"Tell me about the problems you have been having with (child's name's) behaviour?"

(specific behaviour):_____
_____
_____
_____

Personal and Social Information
"Who looks after … from day to day? Is there anyone else involved? Who is usually involved in responding to these problems?"

Who is/are the primary caretaker/s? _____

Presenting Problems
"Give me an example of the problem. Tell me about the last time something like this happened."

Problem (define specific behaviour):_____
_____
_____
_____

When was the problem first noted, and by whom? (Include age/grade, sudden or gradual, noticed personally or brought to attention by someone else)
"How long has this been going on? Tell me about the first example you can remember."

_____
_____
_____

How often does the problem occur, and in what settings?
_____
_____

_____

What is the intensity/severity of the behaviour?
"Have you noticed that the problem is better or worse in certain places, (e.g. school or kindergarten) at certain times or with certain people?"

-Home_____
-Kindergaeten/School_____
-With peers_____
-Other (describe) _____

History of Early Childhood Education Performance
"Have the staff at …. Talked to you about the problem? What have they noticed?"

Current teacher/centre report (Has teacher, principal, counsellor, etc. complained to parents of or noted a need for improvement in child's behaviour or academic performance? Describe complaints)

_____
_____
_____

Previous Treatment
"Have you tried anything to help the problem before? What was that? What happened? "
"Have you spoken to anyone like your family doctor about it?"

_____
_____
_____
_____

Current treatment
"Is there anything you are doing about the problem at the moment? "

Psychoactive medication/Prescribing physician:

_____
_____Date last seen:_____

Psychosocial (describe nature of treatment in detail):

_____
_____

Classroom interventions (describe nature of interventions in detail, including parents' role):
_____
_____

Other:_____

_____

Happy to:

Randomly assigned for intervention	( ) Yes	( ) No
Attend weekly intervention session	( ) Yes	( ) No
Complete questionnaires	( ) Yes	( ) No
Complete daily behavioural chart	( ) Yes	( ) No
Complete intervention task	( ) Yes	( ) No

Structured Intake Interview (Study 2)

Date of Interview:_____

Person(s) been interviewed:_____;Relationship to the child:_____

Child Name: _____ Sex: _____ Age: _____

Reasons for referral

1) Tell me about the problems you have been having with the child's behavior?

_____
_____
_____
_____

Presenting problems

2) Give me an example of the problem. Tell me about the last time something like this happened.

_____
_____
_____
_____

3) When was the problem first noted, and by whom? How long has this been going on? Tell me about the first example you can remember.

_____
_____
_____
_____
_____

4) How often does the problem occur, and in what setting?

_____
_____
_____

5) Have you noticed that the problem is better or worse in certain places, at certain times or with certain people?

_____
_____
_____
_____

6) How do you usually respond to the problem behvaiour? What works? What doesn't work?

_____
_____
_____
_____
_____

7) Is there anything you are doing about the problem at the moment? What kind of help was sought? Who was seen? How frequently? What was advice? What was the outcome?

_____
_____
_____
_____
_____

Child Development

1) How was the pregnancy and birth? (Were there any complications?)

_____
_____
_____
_____
_____

2) Infancy (Were there any problems with feeding, sleeping or crying? Were milestone achieved on time?)

_____
_____
_____
_____
_____
_____
_____
_____

3) Toddlerhood (Was the child active or placid? Were there period of separation? Were there problems with attachment or reunion with parents after separation? Were there any problems with toilet training?)

_____
_____
_____
_____
_____

4) Early childhood (Did the child attend day care or preschooler? How was the adjustment to day care or preschool, any difficulties? How did the child cope with separation from parents? How did the child interact with other children?)

_____
_____

_____
_____
_____
_____
_____

5) Middle childhood (How did the child cope with beginning school? How does the child get on with teachers and classmates? Any disruptive behavior or difficulties like teasing or bullying? Does the child make friends easily?)

_____
_____
_____
_____
_____
_____

6) How does the child get on with brothers and sisters and significant others? Are any problems experienced?

_____
_____
_____
_____
_____

Parental adjustment

1) What life was like for you when you know that you were pregnant?

_____
_____
_____
_____
_____

2) How did you feel immediately after the child was born?

_____
_____
_____
_____

3) What was the father reaction/involvement?

_____
_____
_____
_____
_____

4) How would you describe your relationship with your husband? What has the relationship been like in general?

_____
_____
_____
_____
_____
_____

5) Tell me about the journey being a parent?

_____
_____
_____
_____
_____
_____

6) Give me an example of the worst thing happen between you and your child?

_____
_____
_____
_____
_____

7) How would you describe your relationship with your child?

_____
_____
_____
_____
_____

8) How do you cope with your parenting role and daily stressors? How have you been feeling over the past few weeks? Have you sought any help for emotional or psychological issues?

_____
_____
_____
_____
_____
_____
_____
_____

Appendix F: Family Background Questionnaire

Family Background Questionnaire

This questionnaire collects information on you and your family. Please read and answer every question in this booklet. All information provided will be treated in strict confidence and will not be made available to any other source without your written approval.

Name _____
Address_____
_____Postcode _____
Telephone contact number_____
Today's date_____/_____/_____
(day) (month) (year)

Your Family

1. Child's name : _____
2. Child's sex : Male ( ) Female ( )
3. Child's age today : _____(years)_____ (months)
4. Child's date of birth : _____/_____/_____
(day) (month) (year)

5. Your relationship to this child

Mother (biological or adoptive) ( )
Step-mother ( )
Foster mother ( )
Father (biological or adoptive) ( )
Step-father ( )
Foster father ( )
Other (please describe) _____

6. Your current marital status

Married ( ) Separated ( )
Defacto ( ) Never married ( )
Divorced ( ) Widow/er ( )

7. At the present who lives at home with your child (e.g. parents, siblings, grandparents)?

Name	Age	Sex	Relationship to child

Appendix G: Child Outcome Measures

ECBI™ Eyberg Child Behavior Inventory™

Parent Rating Form by Sheila Eyberg, PhD

Your Name _____ Relationship to Child _____ Today's Date ___/___/___

Child's Name _____ Child's Gender _____ Child's Date of Birth ___/___/___

Directions: Below are a series of phrases that describe children's behavior. Please (1) circle the number describing **how often** the behavior **currently** occurs with your child, and (2) circle either "yes" **or** "no" to indicate whether the behavior is **currently a problem for you**.

For example, if seldom, you would circle the 2 in response to the following statement:

	Never	Seldom	Sometimes	Often		Always	Is this a problem for you?	
1. Refuses to eat vegetables	1	(2)	3	4	5	6	7	YES	(NO)

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

1. Refuses to eat vegetables	1	(2)	(X)	4	5	6	7	YES	(NO)

	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes	Often		Always			
1. Dawdles in getting dressed	1	2	3	4	5	6	7	YES	NO
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	YES	NO
3. Has poor table manners	1	2	3	4	5	6	7	YES	NO
4. Refuses to eat food presented	1	2	3	4	5	6	7	YES	NO
5. Refuses to do chores when asked	1	2	3	4	5	6	7	YES	NO
6. Slow in getting ready for bed	1	2	3	4	5	6	7	YES	NO
7. Refuses to go to bed on time	1	2	3	4	5	6	7	YES	NO
8. Does not obey house rules on own	1	2	3	4	5	6	7	YES	NO
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	YES	NO
10. Acts defiant when told to do something	1	2	3	4	5	6	7	YES	NO
11. Argues with parents about rules	1	2	3	4	5	6	7	YES	NO
12. Gets angry when doesn't get own way	1	2	3	4	5	6	7	YES	NO
13. Has temper tantrums	1	2	3	4	5	6	7	YES	NO
14. Sasses adults	1	2	3	4	5	6	7	YES	NO
15. Whines	1	2	3	4	5	6	7	YES	NO
						Page 1 subtotals			

OVER →

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	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom	Sometimes		Often		Always		
16. Cries easily	1	2	3	4	5	6	7	YES	NO
17. Yells or screams	1	2	3	4	5	6	7	YES	NO
18. Hits parents	1	2	3	4	5	6	7	YES	NO
19. Destroys toys and other objects	1	2	3	4	5	6	7	YES	NO
20. Is careless with toys and other objects	1	2	3	4	5	6	7	YES	NO
21. Steals	1	2	3	4	5	6	7	YES	NO
22. Lies	1	2	3	4	5	6	7	YES	NO
23. Teases or provokes other children	1	2	3	4	5	6	7	YES	NO
24. Verbally fights with friends own age	1	2	3	4	5	6	7	YES	NO
25. Verbally fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
26. Physically fights with friends own age	1	2	3	4	5	6	7	YES	NO
27. Physically fights with sisters and brothers	1	2	3	4	5	6	7	YES	NO
28. Constantly seeks attention	1	2	3	4	5	6	7	YES	NO
29. Interrupts	1	2	3	4	5	6	7	YES	NO
30. Is easily distracted	1	2	3	4	5	6	7	YES	NO
31. Has short attention span	1	2	3	4	5	6	7	YES	NO
32. Fails to finish tasks or projects	1	2	3	4	5	6	7	YES	NO
33. Has difficulty entertaining self alone	1	2	3	4	5	6	7	YES	NO
34. Has difficulty concentrating on one thing	1	2	3	4	5	6	7	YES	NO
35. Is overactive or restless	1	2	3	4	5	6	7	YES	NO
36. Wets the bed	1	2	3	4	5	6	7	YES	NO
							Page 2 subtotals		
							Subtotals from page 1		

Scores	Raw score	*T* score	Exceeds Cutoff (✔)
Intensity			
Problem			

Comments:

Strengths and Difficulties Questionnaire

T 4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that this child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
PEER RELATIONSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐

- Do the difficulties put a burden on you or the class as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Class Teacher/Form Tutor/Head of Year/Other (please specify:)

Thank you very much for your help

Self-Control Rating Scale (SCRS)

Please rate this child according to the descriptions below by circling the appropriate number. The underlined 4 in the center of each row represents where the average child would fall on this item. Please do not hesitate to use the entire range of possible ratings.

1. When the child promises to do something, can you count on him or her to do it?
   Counted 1 2 3 4 5 6 7 Uncounted

2. Does the child butt into games or activities even when he or she hasn't been invited?
   Un-joinable 1 2 3 4 5 6 7 Joined

3. Can the child deliberately calm down when he or she is excited or all wound up?
   Calm 1 2 3 4 5 6 7 Excited

4. Is the quality of the child's work all about the same or does it vary a lot?
   Same 1 2 3 4 5 6 7 Vary

5. Does the child work for long-range goals?
   Long 1 2 3 4 5 6 7 Short

6. When the child asks a question, does he or she wait for an answer, or jump to something else (e.g., new question) before waiting for answer?
   Wait 1 2 3 4 5 6 7 Jump

7. Does the child interrupt inappropriately in conversations with peers, or wait his or her turn to speak?
   Interrupt 1 2 3 4 5 6 7 Wait

8. Does the child stick to what he or she is doing until he or she is finished with it?
   Stick 1 2 3 4 5 6 7 Jump

9. Does the child follow the instructions of responsible adults?
   Followed 1 2 3 4 5 6 7 Neglected

10. Does the child have to have everything right away?
    Rarely 1 2 3 4 5 6 7 Often

11. When the child has to wait in line, does he or she do so patiently?
    Patiently 1 2 3 4 5 6 7 Impatient

12. Does the child sit still?
    Still 1 2 3 4 5 6 7 Active

13. Can the child follow suggestions of others in group projects, or does he or she insist on imposing his or her own ideas?

Followed	1	2	3	4	5	6	7	Imposed

14. Does the child have to be reminded several times to do something before he or she does it?

Un-reminded	1	2	3	4	5	6	7	Reminded

15. When reprimanded, does the child answer back inappropriately?

Appropriately	1	2	3	4	5	6	7
Inappropriately							

16. Is the child accident prone?

In accident	1	2	3	4	5	6	7	Accident

17. Does the child neglect or forget regular chores or tasks?

Un-neglected	1	2	3	4	5	6	7	Neglected

18. Are there days when the child seems incapable of setting down to work?

Aren't	1	2	3	4	5	6	7	Are

19. Would the child more likely grab a smaller toy today or wait for a larger toy tomorrow, if given the choice?

Wait	1	2	3	4	5	6	7	Grab

20. Does the child grab for the belongings of others?

Un-grabbing	1	2	3	4	5	6	7	Grabbed

21. Does the child bother others when they're trying to do things?

Bothered	1	2	3	4	5	6	7
Unbothered							

22. Does the child break basic rules?

Followed	1	2	3	4	5	6	7	Broken

23. Does the child watch where he or she is going?

Watched	1	2	3	4	5	6	7	Unwatched

24. In answering questions, does the child give one thoughtful answer, or blurt out several answers all at once?

Thoughtful	1	2	3	4	5	6	7	Blurt

25. Is the child easily distracted from his or her work or chores?

Undistracted	1	2	3	4	5	6	7	Distracted

26. Would you describe this child more as careful or careless?

Careful	1	2	3	4	5	6	7	Careless

27. Does the child play well with peers (follows rules, waits turn, and cooperates)?

Well	1	2	3	4	5	6	7	Unwell

28. Does the child jump or switch from activity to activity rather than sticking to one thing at a time?

Stick	1	2	3	4	5	6	7	Jumped

29. If a task is at first too difficult for the child, will he or she get frustrated and quit, or first seek help with the problem?

Seek help	1	2	3	4	5	6	7	Frustrated

30. Does the child disrupt games?

Undisrupted	1	2	3	4	5	6	7	Disrupted

31. Does the child think before he or she acts?

Thought	1	2	3	4	5	6	7
Thoughtless							

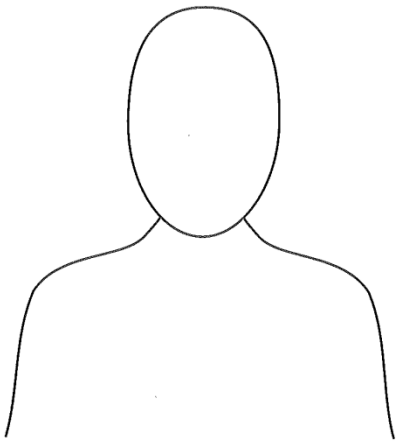
32. If the child paid more attention to his or her work, do you think he or she would do much better than at present?

Better	1	2	3	4	5	6	7	Worse

33. Does the child do too many things at once, or does he or she concentrate on one thing at a time?

One	1	2	3	4	5	6	7	Many

Joseph Picture Self-Concept Scale (JPSCS)



Name/ID#: _____

Date: _____ Age: _____ Grade: _____ Gender: ☐ Female ☐ Male

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Form Y
Young Child Interview

Joseph Picture Self-Concept Scale

AutoScore™ Form

Jack Joseph, Ph.D.

Note:
For detailed administration instructions, see chapter 2 of the Manual.

Please press hard when marking responses.

1.	One of these boys/girls is very clean, and the other boy/girl is very dirty. *Distinguish.* Now which one is most like you? *Confirm.*	[C]	☐ Clean	☐ ?	☐ Dirty
2.	One of these boys/girls has no one to play with, and one of these boys/girls is playing with lots of friends. *Distinguish.* Now which one happens to you the most? *Confirm.*	[C]	☐ No friends	☐ ?	☐ Lots of friends
3.	One of these boys/girls has a teacher who doesn't like him/her very much, and the other boy/girl has a teacher who likes him/her a lot. *Distinguish.* Now which one happens to you the most? *Confirm.*	[C]	☐ Teacher doesn't like	☐ ?	☐ Teacher likes
4.	Let's pretend that your mother and/or father want to visit a beautiful park for one day, but because it costs a lot of money to get into the park, they can take only one boy or girl with them. Who do you think your mother and/or father would pick to go with them to the park—a brother/sister or you? *(For a child with no siblings, do not administer this item and check the box labeled* Self.*)*		☐ Sibling	☐ ?	☐ Self
5.	One of these boys/girls is getting spanked by his/her mother, and the other boy/girl is getting hugged by his/her mother. *Distinguish.* Now which one happens to you the most? *Confirm.*	[C]	☐ Spanked	☐ ?	☐ Hugged
6.	One of these boys/girls has lots of toys to play with, and the other boy/girl has no toys to play with. *Distinguish.* Now which one happens to you the most? *Confirm.*	[C]	☐ Lots of toys	☐ ?	☐ No toys
7.	One of these boys/girls knows how to say lots of words, and the other boy/girl can say only a few words. *Distinguish.* Now which one is most like you? *Confirm.*	[C]	☐ Lots of words	☐ ?	☐ Few words
8.	One of these boys/girls is a slow runner, and the other boy/girl can run very fast. *Distinguish.* Now which one is most like you? *Confirm.*	[C]	☐ Slow runner	☐ ?	☐ Fast runner
9.	This boy/girl likes his/her first name, and the other boy/girl does not like his/her first name. Now which one is most like you? *Confirm.*		☐ Likes name	☐ ?	☐ Dislikes name
10.	One of these boys/girls can jump very high, and the other boy/girl can't jump very much at all. *Distinguish.* Now which one is most like you? *Confirm.*	[C]	☐ Jumps high	☐ ?	☐ Can't jump

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Please press hard when marking responses.

11.	These two boys/girls are playing baseball. One boy/girl wins the game, and the other boy/girl loses the game. *Distinguish.* Now which one happens to you the most? *Confirm.*	C	☐ Wins	☐ ?	☐ Loses
12.	Here are two boys/girls who are dressed up as pumpkins for a Halloween party. One boy/girl gets lots of candy at the party, and the other boy/girl gets only a little candy. *Distinguish.* Now which one happens to you the most? *Confirm.*	C	☐ Lots of candy	☐ ?	☐ Little candy
13.	One of these boys/girls is a bad boy/girl at home, and the other boy/girl is a good boy/girl at home. *Distinguish.* Now which one are you? *Confirm.*	C	☐ Bad at home	☐ ?	☐ Good at home
14.	One of these boys/girls is smiling, and the other boy/girl is crying. *Distinguish.* Now which one do you do the most? *Confirm.*	C	☐ Smiling	☐ ?	☐ Crying
15.	This boy/girl does not like where he/she lives, and the other boy/girl likes where he/she lives. Now which one is most like you? *Confirm.*		☐ Doesn't like where lives	☐ ?	☐ Likes where lives
16.	One of these boys/girls is a bad boy/girl at school, and the other boy/girl is a good boy/girl at school. *Distinguish.* Now which one are you? *Confirm.*	C	☐ Bad at school	☐ ?	☐ Good at school
17.	These two boys/girls had to move far away to a new place. After moving there, this boy/girl makes lots of new friends, and the other boy/girl does not make any new friends. Now which one happens to you the most? *Confirm.*		☐ Makes friends	☐ ?	☐ Doesn't make friends
18.	In school, this boy's/girl's teacher likes his/her work, and the other boy's/girl's teacher does not like his/her work. Now which one happens to you the most? *Confirm.*		☐ Teacher likes	☐ ?	☐ Teacher doesn't like
19.	These two boys/girls are looking at themselves in a mirror. This boy/girl does not like the way he/she looks, and the other boy/girl does like the way he/she looks. Now which one is most like you? *Confirm.*		☐ Doesn't like looks	☐ ?	☐ Likes looks
20.	These two boys/girls are helping their parent(s) clean and fix things around their home. This boy/girl does not do a good job helping, and the other boy/girl does do a good job helping. Now which one happens to you the most? *Confirm.*		☐ Doesn't help	☐ ?	☐ Helps
21.	This boy/girl is invited to all of their birthday parties, and the other boy/girl is not invited to any of their birthday parties. Now which one happens to you the most? *Confirm.*		☐ Invited	☐ ?	☐ Not invited

Appendix H: Parent Outcome Measures

Parenting Scale

Child's Name: _____ Today's Date: _____

Sex: Boy _____ Girl _____ Child's Birthdate: _____

Instructions:

At one time or another, all children misbehave or do things that could be harmful, that are " wrong", or that parents don't like. Example include:

hitting someone	*whining*	*not picking up toys*
forgetting homework	*throwing food*	*refusing to go to bed*
having a tantrum	*lying*	*wanting a cookie before dinner*
running into the street	*arguing back*	*coming home late*

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, fill in the circle that best describes your style of parenting during the past two months with the child indicated above.

SAMPLE ITEM:

At meal time…

I let my child decide how much to eat.	0---0---●---0---0---0---0	I decide how much my child eats.

1. **When my child misbehaves…**

I do something right away.	0---0---0---0---0---0---0	I do something about it later.

2. **Before I do something about a problem…**

I give my child several reminders or warnings.	0---0---0---0---0---0---0	I use only one reminder or warning.

3. **When I'm upset or under stress…**

I am picky and on my child's back.	0---0---0---0---0---0---0	I am no more picky than usual.

4. **When I tell my child not to do something…**

I say very little.	0---0---0---0---0---0---0	I say a lot.

5. When my child pesters me…

I can ignore the pestering.	0---0---0---0---0---0---0	I can't ignore pestering.

6. When my child misbehaves…

I usually get into a long argument with my child.	0---0---0---0---0---0---0	I don't get into an argument.

7. I threaten to do things that…

I am sure I can carry out.	0---0---0---0---0---0---0	I know I won't actually do.

8. I am the kind of parent that…

set limits on what my child is allowed to do.	0---0---0---0---0---0---0	lets my child do whatever he/she wants.

9. When my child misbehaves…

I give my child a long lecture.	0---0---0---0---0---0---0	I keep my talks short and to the point.

10. When my child misbehaves…

I raise my voice or yell.	0---0---0---0---0---0---0	I speak to my child calmly.

11. If saying "No" doesn't work right away…

I take some other kind of action.	0---0---0---0---0---0---0	I keep talking and try to get through to my child.

12. When I want my child to stop doing something…

I firmly tell my child to stop.	0---0---0---0---0---0---0	I coax or beg my child to stop.

13. When my child is out of my sight…

I often don't know what my child is doing.	0---0---0---0---0---0---0	I always have a good idea of what my child is doing.

14. After there's been a problem with my child…

I often hold a grudge.	0---0---0---0---0---0---0	things get back to normal quickly.

15. When we're not at home…

I handle my child the way I do at home. 0---0---0---0---0---0---0 I let my child get away with a lot more.

16. When my child does something I don't like…

I do something about it every time it happens. 0---0---0---0---0---0---0 I often let it go.

17. When there is a problem with my child…

things build up and I do things I don't mean to do. 0---0---0---0---0---0---0 things don't get out of hand.

18. When my child misbehaves, I spank, slap, grab, or hit my child…

never or rarely. 0---0---0---0---0---0---0 most of the time.

19. When my child doesn't do what I ask…

I often let it go or end up doing it myself. 0---0---0---0---0---0---0 I take some other action.

20. When I give a fair threat or warning…

I often don't carry it out. 0---0---0---0---0---0---0 I always do what I said.

21. If saying "No" doesn't work…

I take some other kind of action. 0---0---0---0---0---0---0 I offer my child something nice so he/she will behave.

22. When my child misbehaves…

I handle it without getting upset. 0---0---0---0---0---0---0 I get so frustrated or angry that my child can see I'm upset.

23. When my child misbehaves…

I make my child tell me why he/she did it. 0---0---0---0---0---0---0 I say "No" or take some other action.

24. If my child misbehaves and then acts sorry…

I handle the problem like I usually would. 0---0---0---0---0---0---0 I let it go that time.

25. When my child misbehaves…

I rarely use bad language or curse.	0---0---0---0---0---0---0	I almost always use bad language.

26. When I say my child can't do something…

I let my child do it anyway.	0---0---0---0---0---0---0	I stick to what I said.

27. When I have to handle a problem…

I tell my child I'm sorry about it.	0---0---0---0---0---0---0	I don't say I'm sorry.

28. When my child does something I don't like, I insult my child, say mean things, or call my child names…

never or rarely.	0---0---0---0---0---0---0	most of the time.

29. If my child talks back or complains when I handle a problem…

I ignore the complaining and stick to what I said.	0---0---0---0---0---0---0	I give my child a talk about not complaining.

30. If my child gets upset when I say "No"…

I back down and give in to my child.	0---0---0---0---0---0---0	I stick to what I said.

Parenting Stress Index – Short Form (Study 2)

PSI-4 SHORT FORM

Record/Profile Form

Richard R. Abidin, EdD

Instructions:

On the inside of this form, write your name, gender, date of birth, ethnic group, and marital status; today's date; and your child's name, gender, and date of birth. This questionnaire contains 36 statements.

Read each statement carefully. For each statement, please focus on the child you are most concerned about and circle the response that best represents your opinion. **Answer all questions about the same child.**

Circle SA if you strongly agree with the statement.
Circle A if you agree with the statement.
Circle NS if you are not sure.
Circle D if you disagree with the statement.
Circle SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. **Your first reaction to each question should be your answer.**

Circle only one response for each statement, and respond to all statements. **Do not erase!** If you need to change an answer, mark an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS (X) (SD)

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PSI-4 SHORT FORM

Answer Sheet

Name _____ Gender _____ Date of birth ___/___/___

Ethnic group _____ Marital status _____ Today's date ___/___/___

Child's name _____ Child's gender _____ Child's date of birth ___/___/___

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8.	Having a child has caused more problems than I expected in my relationship with my spouse/parenting partner.	SA	A	NS	D	SD
9.	I feel alone and without friends.	SA	A	NS	D	SD
10.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
11.	I am not as interested in people as I used to be.	SA	A	NS	D	SD
12.	I don't enjoy things as I used to.	SA	A	NS	D	SD
13.	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
14.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
15.	My child smiles at me much less than I expected.	SA	A	NS	D	SD
16.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
17.	My child is very emotional and gets upset easily.	SA	A	NS	D	SD
18.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
19.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
20.	My child is not able to do as much as I expected.	SA	A	NS	D	SD
21.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD
22.	I feel that I am: (Choose a response from the choices below.)	1	2	3	4	5
23.	I expected to have closer and warmer feelings for my child than I do, and this bothers me.	SA	A	NS	D	SD
24.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD

1. a very good parent.
2. a better-than-average parent.
3. an average parent.
4. a person who has some trouble being a parent.
5. not very good at being a parent.

SA = Strongly Agree	A = Agree	NS = Not Sure	D = Disagree	SD = Strongly Disagree

25.	My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
26.	My child generally wakes up in a bad mood.	SA	A	NS	D	SD
27.	I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
28.	Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house.	SA	A	NS	D	SD
29.	My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
30.	When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
31.	My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD
32.	I have found that getting my child to do something or stop doing something is: (Choose a response from the choices below.)	1	2	3	4	5

1. much harder than I expected.
2. somewhat harder than I expected.
3. about as hard as I expected.
4. somewhat easier than I expected.
5. much easier than I expected.

33.	Think carefully and count the number of things which your child does that bothers you. For example, dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. (Choose a response from the choices below.)	1	2	3	4	5

1. 1-3
2. 4-5
3. 6-7
4. 8-9
5. 10+

34.	There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
35.	My child's behavior is more of a problem than I expected.	SA	A	NS	D	SD
36.	My child makes more demands on me than most children.	SA	A	NS	D	SD

PSI-SF (Parent-Child Dysfunctional Interactional Subscale-P-CDI)

SA=Strongly Agree A=Agree NS=Not Sure D=Disagree SD=Strongly Disagree						
1	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
2	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
3	My child smiles at me much less than I expected.	SA	A	NS	D	SD
4	When I do things for my child, I get the feeling my efforts are not appreciated much.	SA	A	NS	D	SD
5	When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
6	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
7	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
8	My child is not able to do as much as I expected.	SA	A	NS	D	SD
9	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD
10	For the next statement, choose your response from the choices "1" to "5" below. I feel I am: 1. not very good at being a parent 2. a person who has some trouble being a parent 3. an average parent 4. a better than average parent 5. a very good parent	1	2	3	4	5
11	I expected to have warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
12	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD

Consumer Satisfaction Questionnaire (Study 1)

This questionnaire will help us to evaluate the quality of the program we offer. We are interested in your honest opinions about the services you have received, whether they are positive or negative. Please answer all the questions.

Please circle the response that best describe how you honestly feel.

1. How would you rate the quality of the programme you received?

   Excellent 5 4 3 2 1 Poor

2. Did you find the programme helpful for you to deal more effectively with your child's behaviour?

   Very Helpful 5 4 3 2 1 Not Helpful

3. Did you find the programme helpful for you to deal more effectively with problems that arise in your family?

   Very Helpful 5 4 3 2 1 Not helpful

4. Do you find the programme helpful to improve your relationship with your child?

   Very Helpful 5 4 3 2 1 Not helpful

5. Do you find the programme helpful for you to develop skills that can be applied to other family members?

   Very Helpful 5 4 3 2 1 Not helpful

6. In overall, how satisfied are you with the program you received?

   Very Satisfied 5 4 3 2 1 Dissatisfied

7. How would you describe your feelings about your child's progress?

   Very Satisfied 5 4 3 2 1 Dissatisfied

8. In your opinion, how is your child's behaviour at this point?

Greatly Improved 5 4 3 2 1 Worse

9. Would you recommend this programme to others? **YES NO**

10. If you are able to, would you willing to pay for this programme? **YES NO**

11. Do you have any comments you would like to make about this programme?

_____

_____

Parent Feedback Interview (Study 2)

1. Were there any changes that you have noticed on yourself since attending the programme?
2. Were there any changes that you have noticed on your child since attending the programme?
3. Was there a part of the programme which was particularly helpful or unhelpful for you?
4. Was there any part of the programme you wish had been done differently?
5. How would you describe this programme to others?
6. Do you have any other comments regarding the programme?

Appendix I: Parent Diaries

Daily Behavioural Chart (Study 1)

Family: _____ Week: _____

The three behaviours listed in each table have been indicated by you as your child's current behavioural problem by referring to the Parent Weekly Report Checklist.

Task: Plot the number of times each behaviour occur each day by placing a cross in the appropriate column.

F: Frequency

D: Day

Behaviour:							
30							
29							
28							
27							
26							
25							
24							
23							
22							
21							
20							
19							
18							
17							
16							
15							
14							
13							
12							
11							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
F /	D 1	D 2	D 3	D 4	D 5	D 6	D 7

Behaviour:							
30							
29							
28							
27							
26							
25							
24							
23							
22							
21							
20							
19							
18							
17							
16							
15							
14							
13							
12							
11							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
F /	D 1	D 2	D 3	D 4	D 5	D 6	D 7

Behaviour:							
30							
29							
28							
27							
26							
25							
24							
23							
22							
21							
20							
19							
18							
17							
16							
15							
14							
13							
12							
11							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
F /	D 1	D 2	D 3	D 4	D 5	D 6	D 7

Parent Behaviour Diary (Study 2)

Family: _____ Week of:_____

	Frequency	Day ___ Date ___	Day ___ Date ___	Day ___ Date ___	Day ___ Date ___	Day ___ Date ___	Day ___ Date ___	Day ___ Date ___
< Name of behaviour >	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
Notes (about child's changes this week; special events):								

Appendix J: Coding Systems

Dyadic Parent-Child Interaction Coding System (Study 1)

A 35-minute video recorded clinic observation of parent-child interaction will take place at pre intervention, post intervention and again at 6-months follow-up. Parent will be required to carry out three different situations which vary in the degree of parental control: a) Child-Led Play (20 min), b) Parent-Led Play (10 min), and c) Clean-up (5 min). In this study, the Dyadic Parent-Child Interaction Coding System-II (Eyberg et al., 1994) will be utilized as a single coding system.

Instructions for the Three Standard Situations

1) Child-Led Play
"In this situation tell _____ that he/she may play with whatever he/she chooses. Let him/her choose any activity he/she wishes. You just follow his/her lead and play along with him/her."

After the 5-minute warm-up period, the parent is told:
"You're doing a nice job of letting _____ lead the play. Please continue to let him/her lead."

2) Parent-Led Play
"That was fine. Please do not clean up the toys at this time. Now we'll switch to the second situation. Tell _____ that it is your turn to choose the game. You may choose any activity. Keep him/her playing with you according to your rules."

After the 5-minute PLP warm-up period, the parent is told:
"You're doing a nice job of leading the play. Please continue to get _____ to play along with you according to your rules."

3) Clean-Up
"That was fine. Now please tell _____ that it is time to leave the playroom and the toys must be put away. Make sure you have him/her put the toys away by him/herself. Have him/her put all the toys in their containers and all the containers in the toy box."

DPICS Coding Sheet (Study 1)

Family : _____ Date:_____

Observer :_____

Parent: □ Mother □ Father □ Other: _____

Situation: □ CLP □ PLP □ CU

Observation ID: _____

PARENT BEHAVIOR	TALLY	CHILD BEHAVIOR	TALLY
Direct Commands (DC) followed by:		Comply to Direct and Indirect Commands	
		Answer Information Questions	
Compliance (CO)			
Noncompliance (NC)			
No Opportunity (NOC)			
Indirect Commands (IC) followed by:			
Compliance (CO)			
Noncompliance (NC)			
No Opportunity (NOC)			
Information Questions (IQ) followed by:			
Answer (AN)		**Notes:**	
No Answer (NA)			
No Opportunity (NOA)			
Descriptive/Reflective Questions (DQ)			
Behavioural Descriptions (BD)			
Reflections (RF)			
Labelled Praise (LP)			
Unlabelled Praise (UP)			

DPICS Sequential Data Recording Sheet

Subject #: _____ Date: _____ Observer: _____

Child's Name: _____ Parent: ❑ Mother ❑ Father ❑ Other: _____

Observation #: _____ Situation: ❑ CLP ❑ PLP ❑ CU

Parent	Interval # __	Interval # __	Interval # __	Parent	Interval # __	Interval # __	Interval # __	Parent
DC-CO				DC-CO				DC-CO
DC-NC				DC-NC				DC-NC
DC-NOC				DC-NOC				DC-NOC
IC-CO				IC-CO				IC-CO
IC-NC				IC-NC				IC-NC
IC-NOC				IC-NOC				IC-NOC
IQ-AN				IQ-AN				IQ-AN
IQ-NA				IQ-NA				IQ-NA
IQ-NOA				IQ-NOA				IQ-NOA
DQ				DQ				DQ
BD				BD				BD
RF				RF				RF
LP				LP				LP
UP				UP				UP
TA				TA				TA
NTA				NTA				NTA
PTO				PTO				PTO
NTO				NTO				NTO
Child				**Child**				**Child**
NTA				NTA				NTA
PRO				PRO				PRO
QU				QU				QU
CM				CM				CM
WH				WH				WH
YE				YE				YE
PTO				PTO				PTO
NTO				NTO				NTO

Dyadic Parent-Child Interaction Coding System (Study 2)

A 20-minute video recorded clinic observation of parent-child interaction will take place at baseline, during intervention period, post-intervention and again at 3-month follow-up. Parent will be required to carry out a Child-Led Play (20 min) session during each observation. In this study, the *Dyadic Parent-Child Interaction Coding System-II* (Eyberg et al., 1994) will be ultilised as one of the coding systems.

Instructions for the Child-Led Play Situation

1) Child-Led Play
"In this situation tell _____ that he/she may play with whatever he/she chooses. Let him/her choose any activity he/she wishes. You just follow his/her lead and play along with him/her."

After the 5-minute warm-up period, the parent is told:
"You're doing a nice job of letting _____ lead the play. Please continue to let him/her lead."

Toward the end of the observation, the parent will be given a reminder five minutes prior to the conclusion of the play session.

DPICS Coding Sheet (Study 2)

Family : _____ Date:_____

Observer :_____

Parent: □ Mother □ Father □ Other: _____

Situation: □ CLP □ PLP □ CU

Observation ID: _____

PARENT BEHAVIOR	TALLY	CHILD BEHAVIOR	TALLY
Direct Commands (DC) followed by:		Positive Affect (PT) Ex: Smile, Laugh, Giggle, etc	
		Positive Touch (PTO) Ex: Hug, Kiss, cuddle, etc	
Compliance (CO)			
Noncompliance (NC)		Question (QU)	
No Opportunity (NOC)		Command (CM)	
Indirect Commands (IC) followed by:			
Compliance (CO)			
Noncompliance (NC)			
No Opportunity (NOC)			
Information Questions (IQ) followed by:			
		Other (specify)	
Answer (AN)		**Notes:**	
No Answer (NA)			
No Opportunity (NOA)			
Descriptive/Reflective Questions (DQ)			
Behavioural Descriptions (BD)			
Reflections (RF)			
A-C-T Limit Setting (ACT)			
Positive Choices (PC)			
Choice-Giving as Consequences (CGC)			
Esteem-Building (EB)			

Coding Form for Child Play Activities according to the Modified Version of Benedict's Expanded Themes in Play Therapy (BETPT)

Study 2

Time	Duration	Child's Play/Activity/Action	Play Theme	Category

Categories of play themes

Category	Play theme
Neutral (NE)	Exploration (EX)
Active-Working (AW)	Aggression (AG), Attachment (AT), Safety (ST), Doing-and-Undoing (DU), Self-nurturing (SN), Failed Nurturing (FN), Failed (FL)
Progressive (PG)	Nurturing & Family (NF), Interpersonal-Relationship (IR), Creativity (CT), Mastery (MAS)

Appendix K: The Adapted BETPT and Its Findings

The Modified Version of Benedict's Expanded Themes in Play Therapy

In Study 2, a modified version of *Benedict's Expanded Themes in Play Therapy* (BETPT) was used as a measure of movement of the child's play based on their play behaviours and activities. The original BETPT comprises eight main play-theme codes, including process codes. It was mainly used to interpret or conceptualise a child's subjective expression in the play sessions in clinical practices. The older version of BETPT reported an overall interrater reliability of .67, in Kappa (Benedict et al., 1998 in Holmberg, Benedict, & Hynan, 1998).

The original BETPT coding system was modified to describe the presented play behaviours or activities of each individual child in the weekly video-recorded parent-child play sessions to capture the child's changes in play activities over the experimental period. First, only the main play-theme codes, which represent the child's play behaviours or interaction in the play sessions, were coded at individual levels. Second, to increase the clarity of the child's play behaviours that were represented in each given code, two main play-theme codes in BETPT, namely attachment and family and exploration and mastery, were divided into seven main themes namely, (a) attachment, (b) nurturing and family, (c) self-nurturing, (d) failed nurturing, (e) exploratory and (f) mastery, (g) fail. Third, a non-play activities code was discharged except the art and drawing activities, which were retained but coded as an additional theme of creativity. Talking and playing games were included in the interpersonal-relationship code. The process codes were discharged, except the undoing-and-undoing process code, which was remained but coded as a main play-theme code as itself. The sexualised play was irrelevant with the child population in the present study, thus not coded. The modified version of BETPT comprised a total of 12 play-theme codes, as shown in Table 29 (p.401).

In Study 2, each video-recorded child-led play session was first summarised into a process note and then coded using the modified version of BETPT. Additionally, time length of the observed play themes was charted to indicate the movement and progress of the child in the play sessions. Only the themes observed in the child during the video-recorded child-led play sessions were charted and discussed at individual levels.

Table 29

The Modified Version of Benedict's Expanded Themes in Play Therapy

Original BETPT		Modified BETPT	
Main Theme	Sub-themes/Example	Main Theme	Subthemes/Example
Aggressive	Good guys Vs Bad guy Aggression Delinquent acts Death as a result of aggression Natural Death Devouring Powerful figure overcoming weaker figure(s) Seeking or consulting a power figure (including crying for help)	Aggressive	Same
Attachment	Constancy play includes hiding things, naming activities, mirror play, checking for things from previous session. Separation play Reunion.	Attachment	Same
	Nurturing play Sleeping Store and shopping Adult Activities	Nurturing & Family	Nurturing & Family Positive nurturing activities including feeding, making food, hugging, comforting someone and giving valued objects, sleeping, adult activities, store and shopping.
	Self-nurturing Comforting one's self, such as hides under a table and sucks.	Self-nurturing	same

Original BETPT		Modified BETPT	
Main Theme	Sub-themes/Example	Main Theme	Subthemes/Example
	Failed Nurturance Failed Nurturance with abuse Failed Nurturance with neglect Neglect, punishment or abuse of the self	Failed Nurturing	Same
Safety	Burning, burying or drowning, broken play, fixing play, failure to fix, self-fixing, bridge building, instability play, cleaning play, messing play, sorting play, danger, containing play, protective play, rescue play and escape.	Safety	Same
Exploration & Mastery	Checking out toys in the room, asking questions about what is available or how things work, walking around the room.	Exploration	Same
	Builds something or masters a challenge, seeking a sense of competence or achievement.	Mastery	Same
	The child describes self as unable to master something the child attempts, or even if they don't actually attempt the task.	Fail	
Sexualised Play	Sexual activities towards an object Sexual behaviours directed at therapist Sexual talk Sexual curiosity	-	Excluded
Non-Play Activities	Art and drawing	Creative	Writing, drawing and art making, making music using musical instruments.
	Games, does not include rule-based activities.		Not provided in the current study thus is excluded
	Uncodable, without any clear play activity.	Exploration	Same
Interpersonal-relationship Process Codes	Collaboration or cooperation Rejects cooperation Competition Sharing Helping	Interpersonal -relationship	Same In addition to talking and chatting between the parent and child and playing rule-based games,

Original BETPT		Modified BETPT	
Main Theme	Sub-themes/Example	Main Theme	Subthemes/Example
	Protect Independence Control Imitation control Imitation Boundary setting Boundary violations Fusion Affection Anger Sadness Rejection Positive connection Roughhousing Teasing		such as bowling.
Process Codes	A shift in valence of the play, whenever positive behaviour towards a given target is followed by negative behaviour towards the same target.	Doing-and-undoing	Same

Play themes represented the stages of Rogers' personality change. To inform the child's movement and progress in the child-centred play sessions conducted by the parent, in the context of the adapted CPRT model grounded in person-centred theory, the modified BETPT was further adapted in the Study 2. While the BETPT was one of the most inclusive play-theme coding systems to date, it is grounded in attachment and object-related theories (Benedict & Schofield, 2010).

Owing to the difference in the theoretical framework of BETPT and child-centred play in the adapted CPRT, the BETPT has been further modified as the child's movement and progress in the context of child-centred play session might be limited. Therefore, the 12 play-theme codes of the modified BETPT are divided into three categories, namely neutral play, active-working play and progressive play, to indicate the different stages of the child in the child-centred play sessions, based on the play activities engaged in by the child, as displayed in Table 30 (p.404). These three play themes are considered as closely related or

comparable to the process of personality change described in Rogers' writing and the works of some other scholars who referred to Person-Centred Therapy when working with children in play therapy (e.g., L. Guerney, 2001; Ray, 2011; Rogers, 1961).

Table 30

Categories of play themes

Category	Play theme
Neutral	Exploration
Active-Working	Aggression, Attachment, Safety, Doing-and-Undoing, Self-nurturing, Failed Nurturing, Failed
Progressive	Nurturing & Family, Interpersonal-Relationship, Creativity, Mastery

In the context of child-centred play therapy, each child's play in the sessions has a very subjective meaning that needs to be understood within the context of the child's experience. Therefore, a series of play activities engaged in by a child might inform us about the movement, if not progress, of the child in play therapy (Cochran, Cochran, Nordling, McAdam, & Miller, 2010). As the current study was aimed to determine the effect of an adapted CPRT grounded in person-centred therapy, the child's movement or progress toward positivity and self-actualization as defined by Carl Rogers (1942) is of great interest. However, owing to the short time-frame of the current study, the observable changes in a child toward self-actualisation, within the context of child-centred play sessions with the parents, might be limited. In addition, the process of Rogers' personality change is often demonstrated in approximate order of a non-linear direction, if not a distinctive way between individuals. While puzzling, a child's movement and progress toward the direction of positivity and self-actualization in the context of play in child-centred play sessions are of high value for research as well as in clinical practice. Therefore, the effort to capture a

child's changes in his or her play is challenging, yet un-avoidable as play is the major component of the therapy.

In addition, play therapy critics (e.g., Phillips, 1985, 2010) highlighted the shortcomings of play and filial therapy studies in informing the child's progress in the context of play. As this information is generally missing in play and filial therapy studies, Study 2 aims to find a way to determine, and thus inform the readers about the progress made by each individual child in their own context of play, through exploring the types of play activities and behaviours engaged in by each child during the child-centred play session with the parent during the course of the current study. To be informed of the child's changes in the context of play within the person-centred perspective, the terms neutral, active-working, progressive play were used in the current study. The child's changes in the context of play were defined by the play activities engaged in by the child which were coded using the modified version of BETPT. As such, these would be the sub-categories of the play that represent the play terms that reflect the different stages of Rogers' (1942, 1963) process of personality change.

The terms neutral, active-working, progressive play were introduced in the current study based on a review of Rogers' (1942) process of personality change and the works of other play therapy researchers, who mainly referred to Rogers' theory when working with children (e.g., L. Guerney, 2001; Haworth & Wilkins, 2010; Moustaka, 1973; Ray, 2011). These new play themes were used to indicate the stages of Rogers' process of personality change that explains when and how one's changes occur during a therapeutic relationship. They represented a collective of child play activities that was closely related to Rogers' description of changes in personality as well as children's stages of change in play therapy. In referring to Rogers' (1951) theory, each movement or step taken by a client, in the case of the Study 2 – the child, within a therapeutic relationship or therapy could be regarded as the

movement toward self-actualisation. The rationale and the process of developing the three main play themes are discussed as follows.

▪ Neutral play is a term used to describe the early stages of the process of change of Rogers' therapeutic relationship. It represents the three earlier stages of the 12-step process of person-centred therapy (Rogers, 1942), which defined the stages as follows: (a) when the child enters the special home play sessions, (b) when the therapeutic relationship is defined and the child is allowed to lead, and (c) when the parent allows free expression of feelings in the child; the first two stages of Rogers' seven-stage process of personality change that explains (d) when the child resists change and refuses to play, and (e) when the child is less rigid and has started some form of exploratory play and some activities that are familiar to the child which usually involve little emotion. Neutral play is also reflected in Louise Guerney's (2001) first phase of play therapy process, namely "warm-up" which could be observed (f) when a child's play is more focused and less tentative as the child is focused on building a sense of trust and rapport within the new dynamic of parent-child relationship in the special home play sessions. By referring to all the possible descriptions of the early-levels of personality change within Rogers' defined therapeutic relationship, neutral play in the current study is reflected in "exploration" play in the adapted BETPT, which includes checking out toys and play materials, asking questions to obtain information regarding things, structure and roles in the play and play activities that do not have a clear meaning, such as shaking a toy car and checking out some building-blocks.

▪ Active-working play is a term used to describe the middle stages of one in the process of Rogers' therapeutic relationship. It represents the fourth step of the12-step process of person-centred therapy (Rogers, 1942), which refers to (a) when a child expresses negativity or aggressiveness verbally and non-verbally in the play sessions; the third and fourth stages of Rogers' 7-stage process of personality change that illustrate (b) when a child begins to

engage in meaningful play in a way that still allows for emotional distance and (c) when a child begins to feel safe and thus engages in more meaningful play consistently in play sessions for at least a few minutes in each session, (d) when a child expresses his or her emotions more freely through play and possibly with the parent in the play sessions, and (e) when a child increases verbal communication with the parent due to an increased trust in the new dynamic and therapeutic relationship between them. In addition, the second and third phases of GGFT process, namely "aggressive", can be observed (d) when the child demonstrates aggressiveness in play and behaviour, owing to an - increased sense of security, in which an expression of aggressiveness in play sessions is perceived as the child's readiness to deal with his or her issues, needs and feelings underlying the presenting problems, and "regressive", (e) when a child displays lower amounts of aggressive play and, (f) when a child demonstrates some forms of regressed play behaviour or dependent acts, such as wanting to be nurtured or to nurture others in the play sessions. Moustaka (1973) also claimed that the changes in maladjusted and aggressive children in the first and the second stages of play therapy are evident, (g) when a child shows negative emotion through play behaviour, and (h) when the child demonstrates more symbolic play with hostility in nature or acting-out behaviour toward play materials or to the parent in the play session. By referring to all the possible descriptions of the mid-levels of personality change within Rogers' definition of a therapeutic relationship, active-working play in Study 2 is represented in a number of play themes in the adapted BETPT, such as aggression, power and control, attachment, doing-and-undoing, safety, failed-nurturance, self-soothing.

- Progressive play is a term used to describe the advanced stages of one in the process of Rogers' therapeutic relationship. It represents the fifth, sixth, seventh and the eighth steps of the12-step process of person-centred therapy (Rogers, 1942), which refers to (a) when a child expresses his or her positive and negative feelings more freely through play or directed

to the parent verbal and non-verbally; (b) when a child feels that his or her expression is being accepted by the parent, which could be observed through the expression of a mixture of positive and negative feelings and play where the positive expression is more dominant; (c) when a child increases in self-acceptance, which could be observed through more goal-directed play and tasks carried out by the child that involves persistent and persevering acts that produce a sense of gratification in the child, either when it succeeded or failed; (d) when a child shows his or her willingness to make decisions and take actions to accomplish a task or play; the fifth and sixth stages of Rogers' 7-stage process of personality change that show (e) when a child shares a variety of emotions regularly, the child shows more confidence in play and expression and is more responsible for his or her actions and expressions and thus is more directed in his or her play with ease and patience; (f) when a child demonstrates unconditional positive regard for others, especially for the parent in the play sessions, the child shows less demanding behaviour of the parent while the child takes more actions and make decisions and solutions independently (Ray, 2011). Similarly, Moustaka (1973) indicated that the greater progress of a child maladjusted and aggressive in the therapeutic relationship (stages four and five) could be identified (g) when the child displays less anger in his or her play while demonstrating play that contains more positive emotions, and (h) when the child engages in constructive play and demonstrates stability in expressing positive and negative emotions. Louise Guerney (2001) defines the highest phase of the process of play as mastery, (i) when a child engages in competitive games in a mature, honest and responsible manners; (j) when a child helps the parent involuntarily; and (k) when a child demonstrates aptitude in play behaviour and in his or her interaction with the parent. By referring to all the possible descriptions of the advanced-levels of personality change within Rogers's defined therapeutic relationship, progressive play in Study 2 refers to a number of play themes in the

adapted BETPT, which include creative, nurturing and family, relationship-building and mastery play.

Within-Participant Results: Child Play Activities

In this section, child play activities during the 20-minute child-led play sessions were quantified to document child progress in play across the experimental conditions, pertaining to the ninth research question "*Are there adaptive changes in the children's play during the video-recorded parent child play session over the intervention period?*" Adaptive changes would be demonstrated by an increase in active-working play and a decrease in neutral play in early sessions, followed by a gradual decrease in active-working play and an increase in progressive play in the later sessions. However, according to Rogers (1942) the change process occurs in approximate rather than strictly linear order.

Child 5's play.

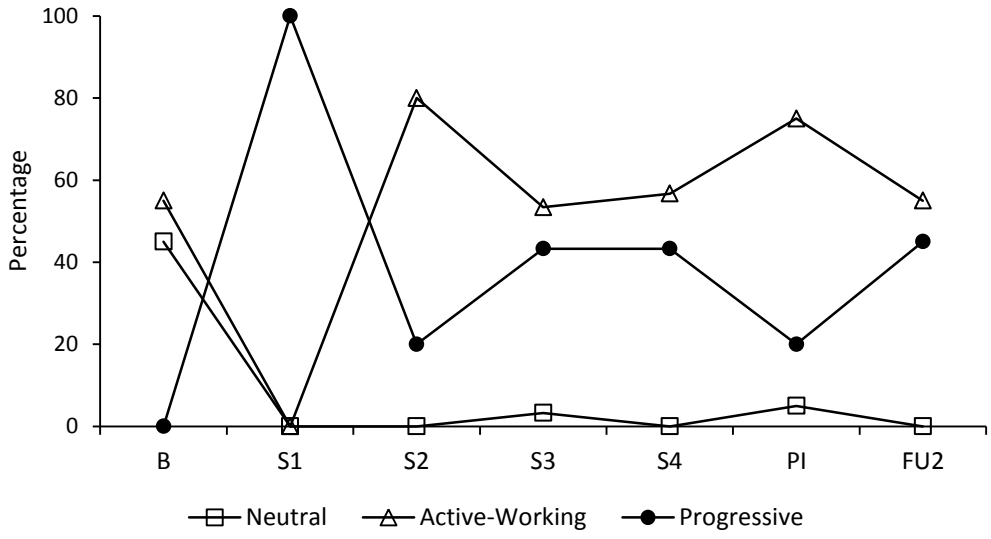


Figure 78. The percentage of neutral, active-working and progressive play activities shown by Child 5 during the 20-minute child-led play observations across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 78 (p.409) shows the percentage of neutral, active-working and progressive play activities engaged by Child 5 during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 5 demonstrated moderate levels of neutral (45%) and active-working (55%) play, while progressive play was not evident. As expected, high levels of neutral play were used by Child 5 at baseline to explore the new toys and setting, which was then largely diminished in the following sessions due to familiarity. This reduction was filled with active-working play (50%-80%), which signifies the child's progress in the sessions during the intervention phase. The child was expected to express and work on his issues through some forms of active-working play, when he perceived a sense of safety through the therapeutic parent-child relationship in the sessions. In addition, Child 5 began to spend his time in some forms of progressive play (20%-45%) during the intervention phase except Session 1, where he fully engaged in progressive play. Child 5 continued the similar trend of active-working and progressive play at after the intervention.

Child 5's active-working play.

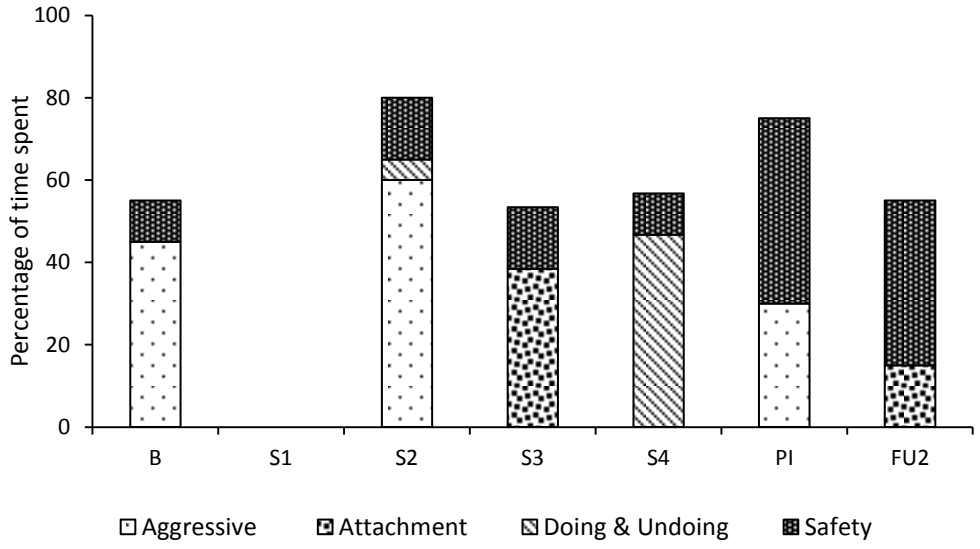


Figure 79. The percentage of time Child 5 spent in the types of active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=baseline; S=session; PI=post-intervention; FU2=Follow-up 2.

Figure 79 (p.410) shows the percentage of time Child 5 spent in the types of active-working play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 5 spent most of the playtime in aggressive play (45%), while relatively less time in safety play (10%). When intervention occurred, Child 5 increased in aggressive (60%), attachment (39%) and doing-and-undoing (47%) play in Session 2, 3 and 4, respectively, while he maintained low levels of safety play (10%-15%) throughout the intervention period. At post-intervention, Child 5 increased in safety play (45%), while he reduced the time he spent in aggressive play (30%) than he had in the previous phases. Similarly at Follow-up 2, Child 5 continued to spend a significant amount of time in safety play (40%) and reduced the time he spent in attachment play (15%).

Child 5's progressive play.

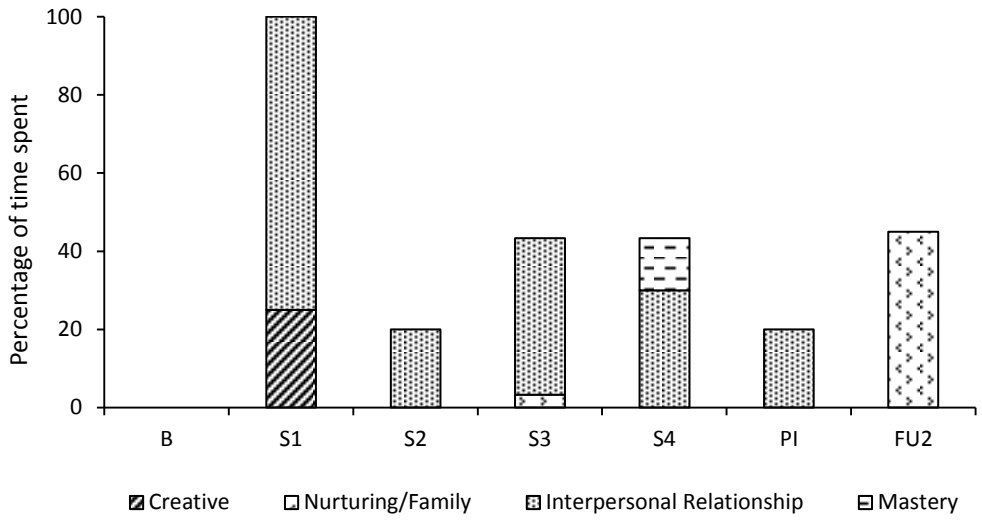


Figure 80. The percentage of time Child 5 spent in the types of progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline, S= Session, PI=Post-intervention; FU2=Follow-up 2.

Figure 80 (p.411) shows the percentage of time Child 5 spent in different types of progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 5 did not engaged in any types of progressive play. When intervention occurred, some forms of interpersonal relationship play (20%-75%) were shown. For example, creative (25%), nurturing and family (3.3%) and mastery (13.3%) play were shown in Session 1, 3 and 4, respectively. At post-intervention, Child 5 only engaged in interpersonal relationship play (20%). At Follow-up 2, Child 5 increased in progressive play and shifted his focus from interpersonal relationship play in the previous sessions to nurturing and family play (45%).

Summary of child 5's play. In terms of child play, Child 5 remained moderate to high levels of active-working play throughout the experimental phases, while he increased in progressive play and reduced in neutral play after implementation of intervention.

Child 6's play.

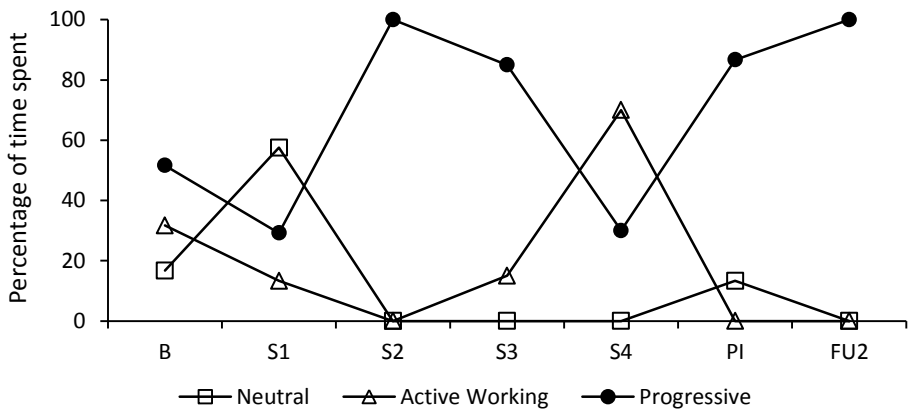


Figure 81. The percentage of neutral, active-working and progressive play activities engaged by child 6 during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 81 shows the percentage of neutral, active-working and progressive play activities engaged by Child 6 during the 20-minute child-led play sessions across the experimental

conditions. At baseline, Child 6 showed moderate levels of progressive play (51.6%) and low levels of active-working (31.7%) and neutral (16.7%) play. During the intervention phase, neutral play was not evident after a marked increase in the earliest session (S1=57.5%). A decrease in active-working play (S1=13.3%; S2=0%) was followed by an increase in the following sessions (S3=15%; S4=70%). Child 6 engaged in more progressive play in mid-intervention sessions (S2=85%; S3=100%), but less during early (29.2%) and late (30%) intervention sessions compared to his baseline. At post-intervention, Child 6 spent more time in progressive play (87%) and some in neutral play (13%), while active-working play was not evident. At Follow-up 2, Child 6 only engaged in some forms of progressive play.

Child 6's active-working play.

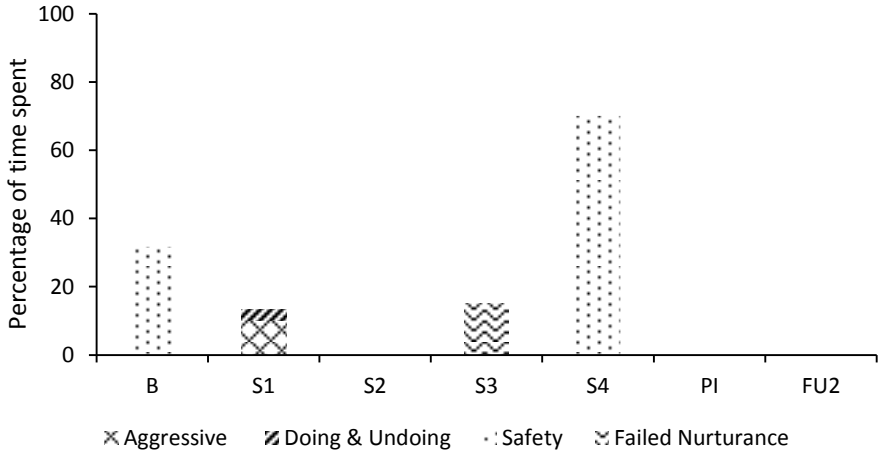


Figure 82. The percentage of time Child 6 spent in different types of active-working play activities during the 20-minute child-led play sessions across experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 82 displays the percentage of time Child 6 spent in different types of active-working play activities during the 20-minute child-led play sessions across experimental conditions. At baseline, Child 6 only engaged in safety play, such as fixing things and

people. During the intervention phase, Child 6 engaged in several types of active-working play, including aggressive (10%) and doing and undoing play (3.3%) in Session 1, failure nurturance (15%) in Session 3. He spent a relatively greater amount of time in the same kind of safety play (70%) activities in Session 4 than he had in baseline. Child 6 did not engage in any types of active-working play activities during post-intervention and Follow-up 2.

Child 6's progressive play.

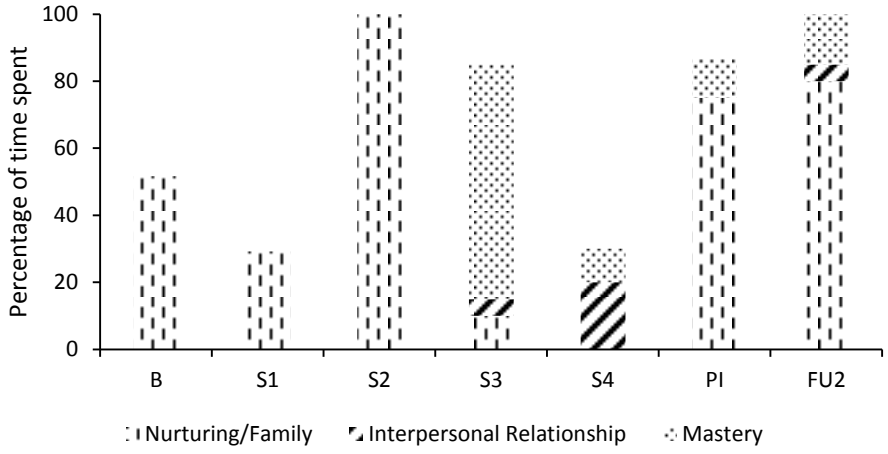


Figure 83. The percentage of time Child 6 spent in different types of progressive play activities during the 20-minute child-led play sessions across experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 83 displays the percentage of time Child 6 spent in different types of progressive play activities during the 20-minute child-led play sessions across experimental conditions. While progressive play was solely represented by nurturing and family play in baseline (61.6%) and early intervention sessions (S1=29%; S2=100%), Child 6 made an obvious shift in his play by using a relatively greater amount of time in mastery play (70%) and less in nurturing and family play (10%) in Session 3. Since then, a persistently low amount of time was spent in mastery play in the subsequent sessions (S4=10%; PI=11.7%; FU2=15%).

Child 6 also spent low levels of time in interpersonal relationship types of play in late intervention sessions (S3=5%; S4=20%) and Follow-up 2 (5%).

Summary of child 6's play. In terms of child play, a marked increase in progressive play was evident during mid-intervention. A decreasing trend in active-working play in early sessions was followed by a sharp increase in play in the late session. Child 6 engaged in high levels of progressive play but none in active-working play after the completion of the intervention.

Child 7's play.

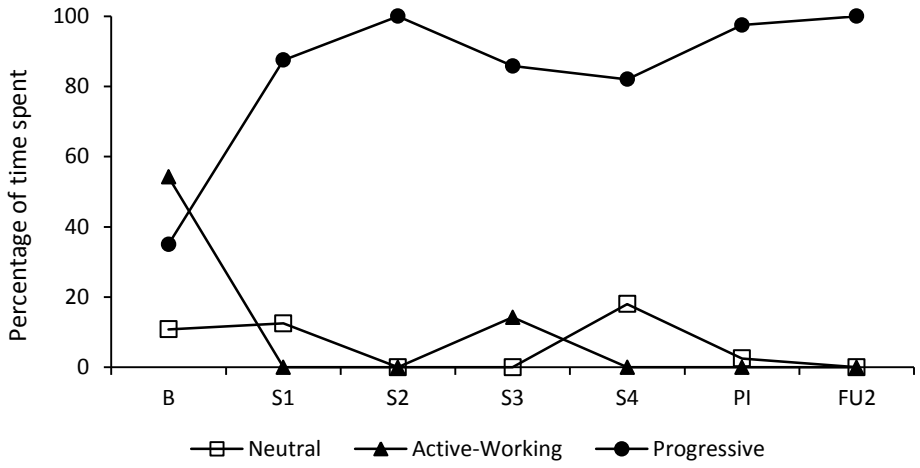


Figure 84. The percentage of neutral, active-working and progressive play activities of Child 7 during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 84 displays the percentage of neutral, active-working and progressive play activities of Child 7 during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 7 demonstrated moderate levels of active-working play (54%) and low levels of progressive (35%) and neutral (11%) play. When intervention occurred, Child 7 increased in progressive play activities (82%-100%) and did not engage in active-working play activities, except in Session 3 (14.2%), while she remained zero to low levels of

neutral play (0%-18%) throughout the intervention phase. After intervention, Child 7 remained high levels of progressive play (97.5%-100%) and low levels of neutral play (0-2.5%), while she disengaged in active-working play activities.

Child 7's active-working play.

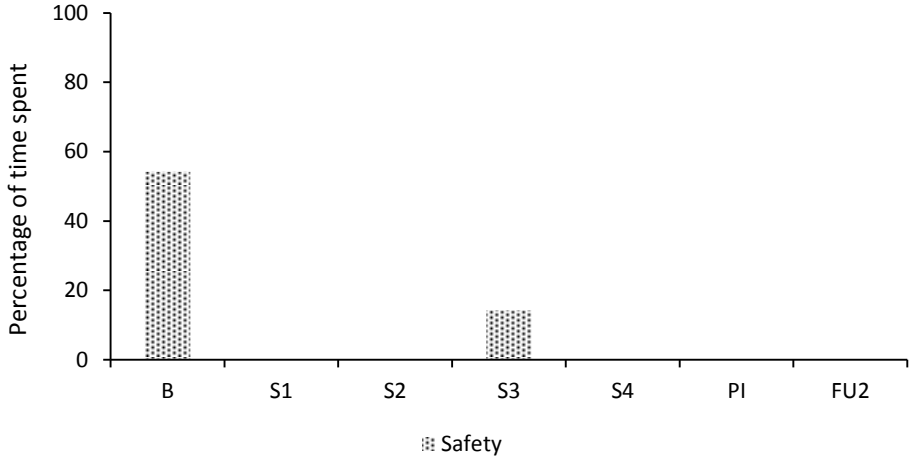


Figure 85. The percentage of time Child 7 spent in different types of active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 85 shows the percentage of time Child 7 spent in different types of active-working play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 7 spent more than half of the play time in safety play (54%), such as doctoring. When intervention occurred, the same type of safety play (15%) was shown once again in Session 3 in a relatively shorter amount of time. Active-working play activities were not evident in post-intervention as well as Follow-up 2.

Child 7's progressive play.

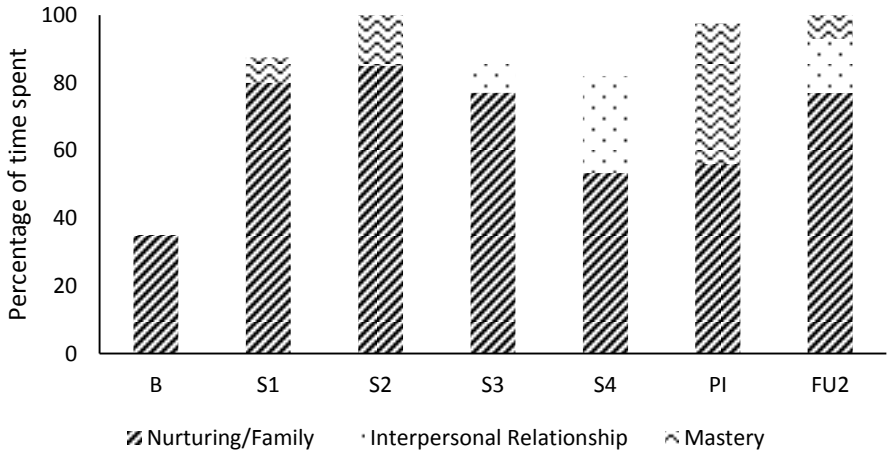


Figure 86. The percentages of time Child 7 spent in different types of progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 86 shows the percentages of time Child 7 spent in different types of progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 7 used approximately one third of the play time in nurturing and family play (35%). When intervention occurred, Child 7 increased in nurturing and family (82%-100%) play activities and initiated some forms of mastery play during early intervention sessions (S1=7.5%; S2=15%), while she shifted her play to interpersonal relationship play activities in late intervention sessions (S3=8.7%; S4=28.65%). At post-intervention, Child 7 increased in mastery play (41.5%) while remaining moderate levels of nurturing and family play (56%). At Follow-up 2, Child 7 once again increased in nurturing and family play (77%) while she remained some forms of interpersonal relationship (16%) and mastery play (7%) activities.

Summary of child 7's play. In terms of child play, Child 7 showed an immediate increase in progressive play and an immediate reduction in active-working play, while she did not engaged in neutral play in late intervention sessions and after the intervention concluded.

Child 8's play.

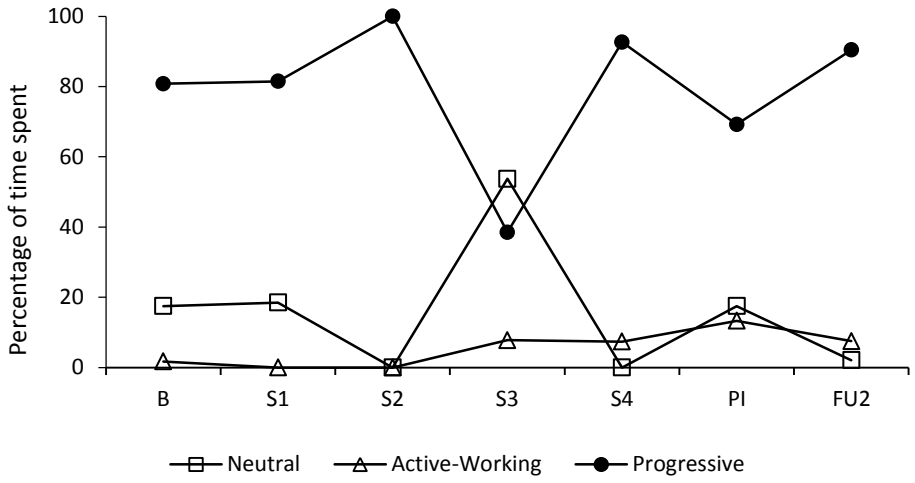


Figure 87. The percentage of neutral, active-working and progressive play activities engaged by Child 8 during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 87 shows the percentage of time Child 8 spent in neutral, active-working and progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 8 demonstrated high levels of progressive play (81%) and low levels of neutral play (17%), while he barely engaged in active-working play (2%). When intervention occurred, Child 8 increased in progressive play (82%-100%) with the exception in Session 3 (39%). A slight increase in active-working play was noted since mid-intervention sessions (S3=8%; S4 =7%). At post-intervention, Child 8 remained high levels of progressive play (70%) and low levels of neutral play (17%), while he increased in active-working play (13%) than he had in baseline. At Follow-up 2, Child 8 demonstrated high

levels of progressive play (90%) and low levels of active-working (8%) and neutral (2%) play.

Child 8's active-working play.

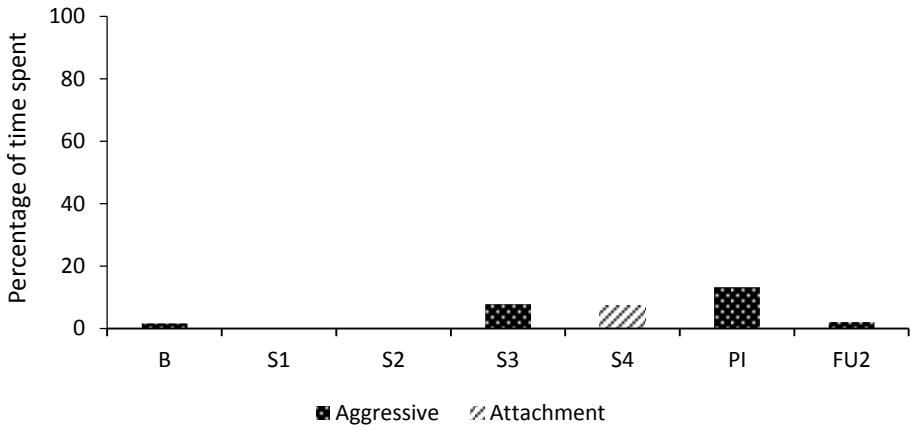


Figure 88. The percentage of time Child 8 spent in active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 88 shows the percentage of time Child 8 spent in active-working play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 8 spent small amount of time in aggressive play (2%). When intervention occurred, active-working play was not evident during early intervention sessions but it was shown during late intervention sessions. For instance, Child 8 demonstrated an increase in aggressive (8%) and attachment (7%) play, such as fighting and hide-and-seek, respectively, than he had in baseline. Child 8 continued to increase in aggressive play (13%) at post-intervention before he reduced it (2%) to the approximate baseline levels at Follow-up 2.

Child 8's progressive play.

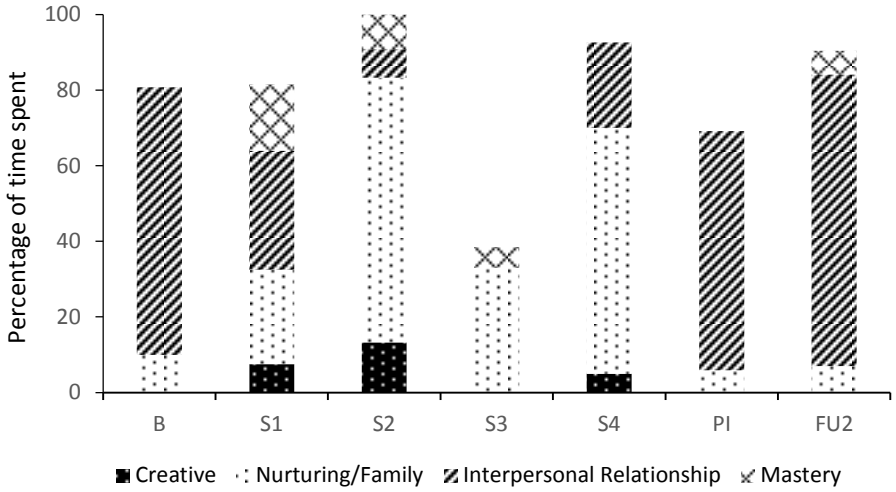


Figure 89. The percentages of time Child 8 spent in progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

Figure 89 shows the percentages of time Child 8 spent in progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 8 spent a great amount of time in interpersonal relationship (71%) play and less in nurturing and family (10%) play. When intervention occurred, Child 8 engaged in more types of progressive play, including creative (S1=7.5%, S2=13%; S4=5%) and mastery (S1=17.5; S2=9.2%; S3=5.5%) play. However, nurturing and family play (25%-70%) remained dominant and consistently shown across the intervention phase. At post-intervention, Child 8 demonstrated high levels of interpersonal relationship play (63%) and low levels of nurturing and family play (6%) and aggressive play (13%). At Follow-up 2, Child 8 remained high levels of interpersonal relationship play (77%) and low levels of mastery (6%) and aggressive (2%) play.

Summary of child 8's play. In terms of child play, Child 8 showed a slight increase in active-working play since mid-intervention session, while he remained high levels of progressive play throughout the experimental phases, except Session 3.

Child 9's play.

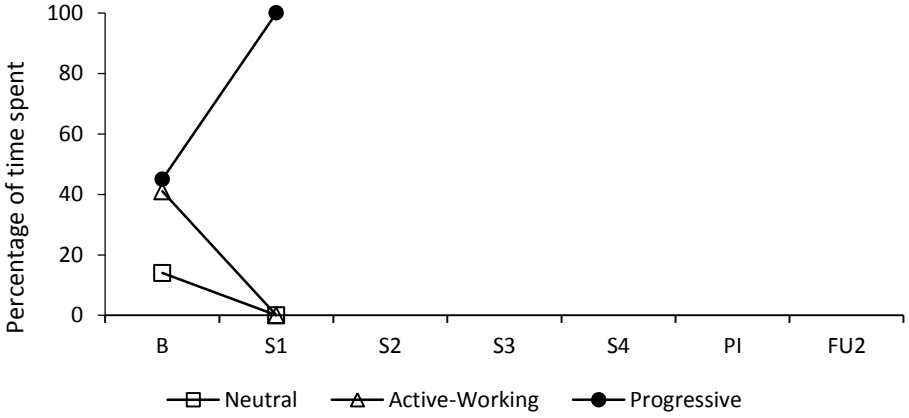


Figure 90. The percentage of neutral, active-working and progressive play activities engaged by Child 9 during the 20-minute child-led play observations across the experimental conditions. *Note.* B=baseline; S=session; PI=post-intervention; FU2=Follow-up 2.

Figure 90 shows the percentages of time Child 9 spent in neutral, active-working and progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 9 demonstrated moderate levels of active-working (41%) and progressive play (45%) and low levels of neutral play (14%). This was followed by a sharp increase in progressive play (100%) at Session 1.

Child 9's active-working play.

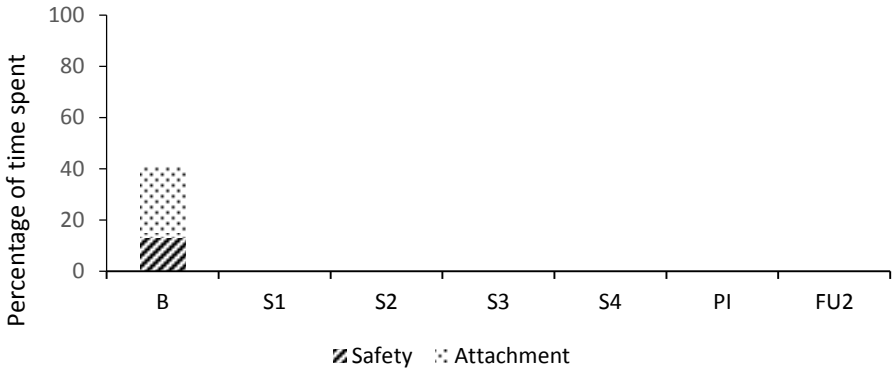


Figure 91. The percentage of time Child 9 spent in active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=baseline; S=session; PI=post-intervention; FU2=Follow-up 2.

Figure 91 show the percentage of time Child 9 spent in active-working play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 9 spent approximately 28% of time in attachment play and 13% of time in some types of safety play, while active-working play activities were not evident in Session 1.

Child 9's progressive play.

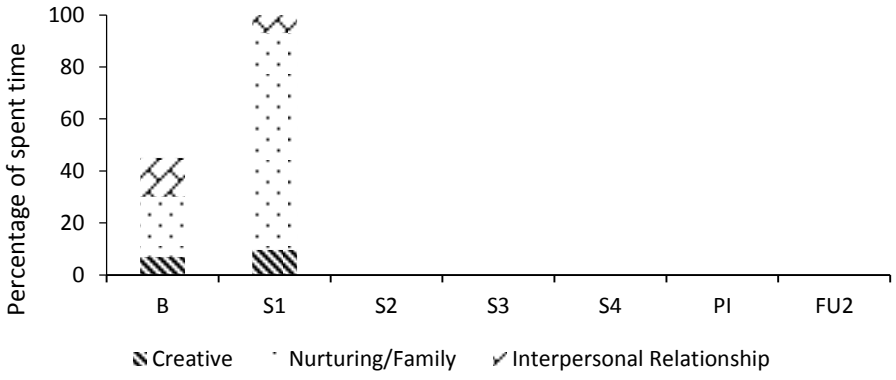


Figure 92. The percentages of time Child 9 spent in progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=baseline; S=session; PI=post-intervention; FU2=Follow-up 2.

Figure 92 (p.422) show the percentage of time Child 9 spent in progressive play during the 20-minute child-led play sessions across the experimental conditions. At baseline, Child 9 spent half of the time in progressive play through nurturing and family play (23%), while the other half was spent in interpersonal relationship (15%) and creative (7%) play. At Session1, Child 9 spent all her play time in the same types of play activities as she had in baseline. Child 9 increased the time she spent in nurturing and family play by approximately 60% compared to baseline, while she spent half of the time she had had in interpersonal relationship play (7%) at baseline. She also spent approximate amount of time in creative play (10%) as she had in baseline.

Summary of Child 9's play. In terms of child play, Child 9 demonstrated a sharp increase in progression play at Session 1 compared to baseline.

Child 10's play.

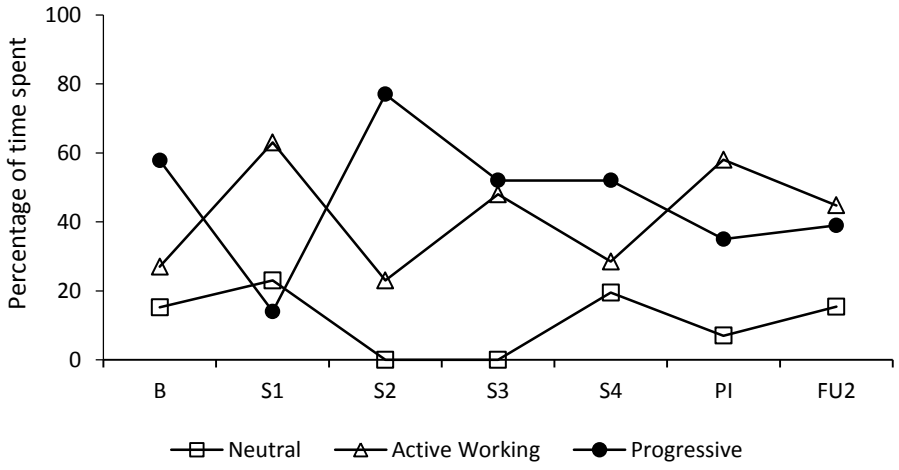


Figure 93. The percentage of neutral, active-working and progressive play activities engaged by Child 10 during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 10 demonstrated moderate levels of progressive play (58%) and low levels of active-working (27%) and neutral (15%) play. When intervention occurred, Child

10 increased in active-working play (29%-63%), with the exception in Session 2 (23%). He demonstrated high levels of progressive play (52%-77%) across the intervention phase, with the exception in Session 1 (14%). While there was a slight increase in neutral play in early (S1=23%) and late (S4=20%) intervention, it was not evident in mid-intervention. After the intervention concluded, Child 10 maintained moderate levels of active-working play (PI=58%; FU2=45%), while he reduced in progressive play (PI=35%; FU2=39%).

Child 10's active-working play.

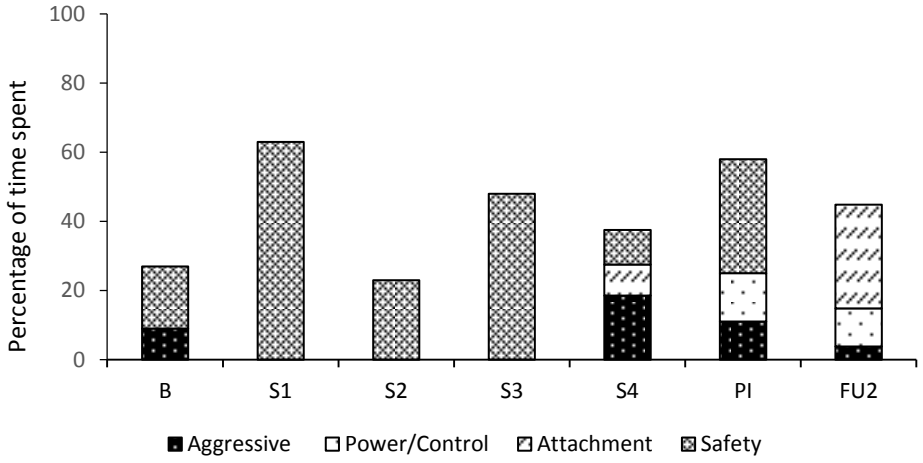


Figure 94. The percentage of time Child 10 spent in active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 10 demonstrated low levels of safety (18%) and aggressive (9%) play. When intervention occurred, safety play was shown predominantly (23%-63%), with the exception in post Session 4 when the child also engaged in attachment (9%) and aggressive (19%) play other than safety play (10%). At post-intervention, Child 10 demonstrated higher levels of safety (33%), aggressive (11%) and power and control (14%) play than he had in baseline. Safety play, however, was not evident at Follow-up 2; Child 10

mainly focused at attachment play (30%) as well as power and control (11%) and aggressive (4%) play.

Child 10's progressive play.

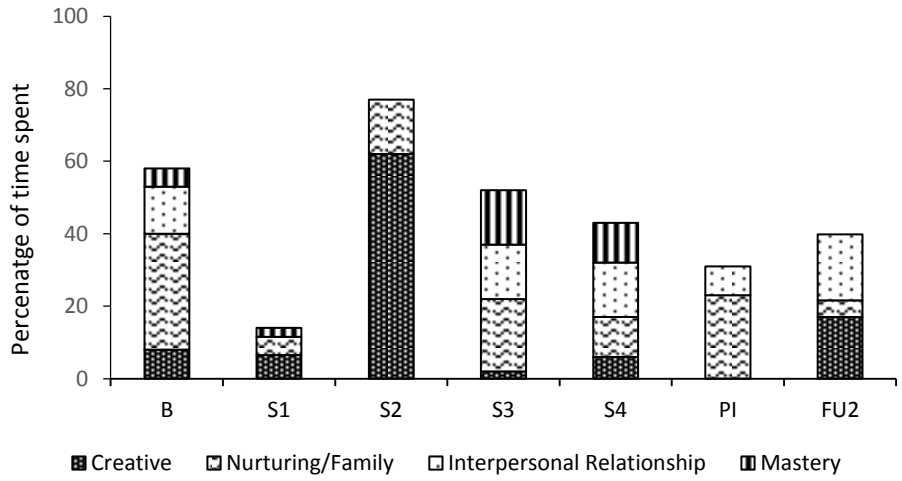


Figure 95. The percentages of time Child 10 spent in progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 10 demonstrated more nurturing and family (32%) play followed by interpersonal relationship (13%), creative (8%) and mastery (5%) play. When intervention occurred, Child 10 demonstrated the similar types of play as he had in baseline with relatively less amount of time, such as creative play (2%-6%), with the exception in post Session 2 (62%), and nurturing and family play (5%-20%). He demonstrated low levels of interpersonal relationship (S3=15%; S4=15%) and mastery (S3=11%; S4=15%) play in late intervention sessions. At post-intervention, he reduced in nurturing and family (23%) and interpersonal relationship (8%) play compared to baseline. At Follow-up 2, he spent increased in interpersonal relationship (18%) and creative (17%) play and reduced in nurturing and family play (5%).

Summary of child 10's play. In terms of child play, Child 10 remained moderate levels of progressive play with a general increasing trend in active-working play. In contrast with other children, he demonstrated an increasing trend in active-working play and a decreasing trend in progressive play.

Child 11's play.

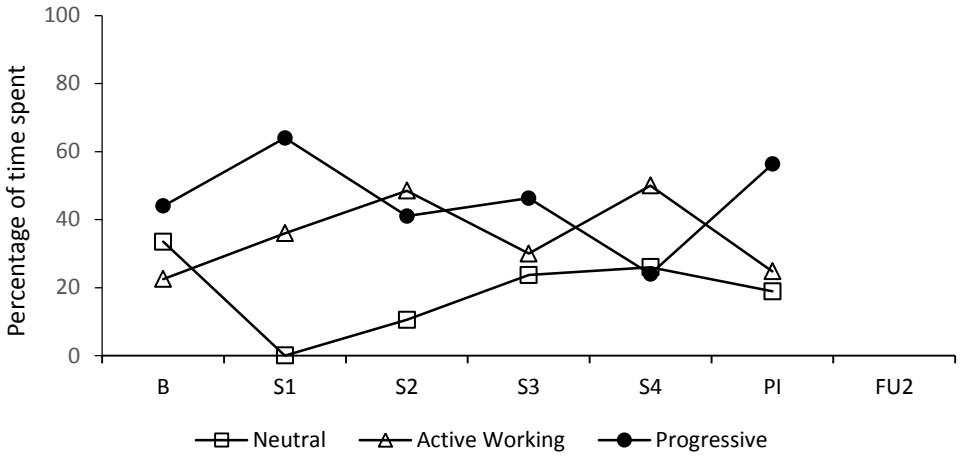


Figure 96. The percentage of neutral, active-working and progressive play activities shown by child 11 during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 11 demonstrated moderate levels of progressive play (44%) and low levels of neutral (36%) and active-working (22%) play. When intervention occurred, Child 11 remained moderate levels of progressive play (41%-64%), with the exception in Session 4 (24%), while he increased in active-working play (30%-50%) and reduced in neutral play (0%-26%). At post-intervention, Child 11 remained moderate levels of progressive play (56%) and low levels of active-working play (25%) as he did in baseline, while he reduced in neutral play (19%).

Child 11's active-working play.

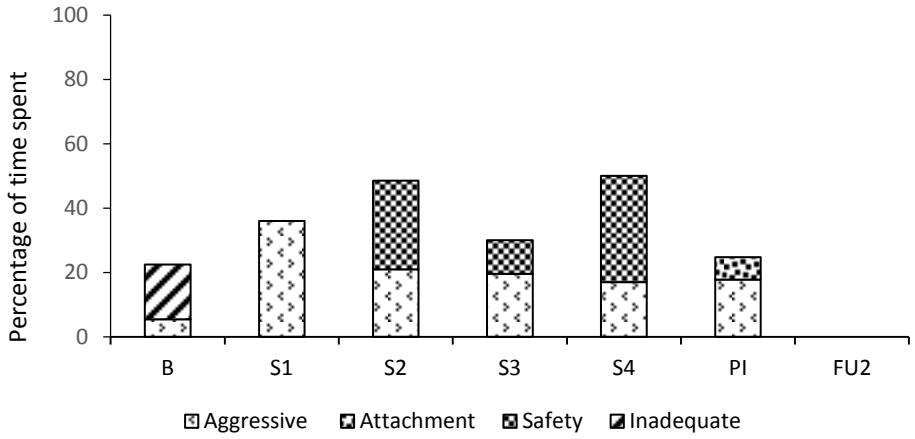


Figure 97. The percentage of time Child 11 spent in different types of active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 11 showed low levels of inadequate (17%) and aggressive (6%) play. When intervention occurred, Child 11 increased in aggressive play (17%-36%), while he initiated some forms of safety play (10%-33%) from Session 2 (27.5%) to Session 4 (33%). At post-intervention, Child 11 continued to spend a significant amount of time in aggressive play (18%) as he did during the intervention, while he initiated some forms of attachment play (7%).

Child 11's progressive play.

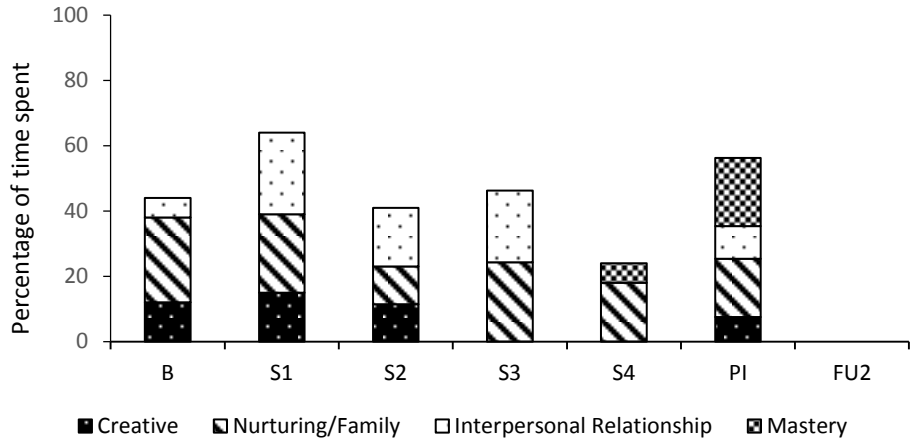


Figure 98. The percentages of time Child 11 spent in the different forms of progressive play during the 20-minute child-led play sessions across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 11 spent more time in nurturing and family play (26%) following by creative (12%) and interpersonal relationship (6%) play. When intervention occurred, Child 11 increased in interpersonal relationship play (18%-25%), with the exception in Session 4 (0%). Nurturing and family play (12%-24%) was continued to show throughout the intervention phase, while creative play was evident in early intervention sessions (S1=15%; S2=11.5%). At post-intervention, Child 11 initiated some forms of mastery play (21%) apart from the similar types of play he engaged in during baseline, including nurturing and family (18%), creative (7%) and interpersonal relationship (10%) play.

Summary of child 11's play. In terms of child play, Child 11 showed an increasing trend in active-working play and a decreasing trend in progressive play, after an initial increase, during the intervention phase. An increasing trend in neutral play was evident from

session 2, while Child 11 remained moderate levels of progressive play and low levels of active-working play after the completion of the intervention.

Child 12's play.

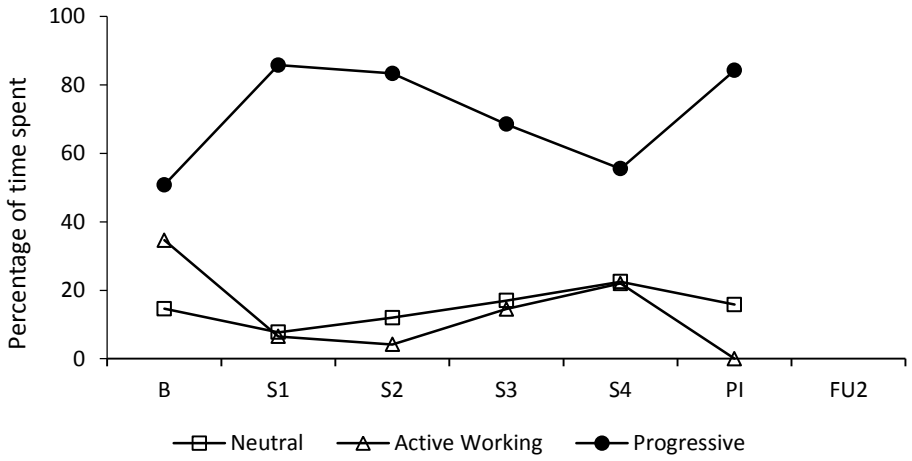


Figure 99. The percentage of neutral, active-working and progressive play activities shown by Child 12 during the 20-minute child-led play observations across the experimental conditions. *Note*. B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 12 demonstrated moderate levels of progressive play (51%) and low levels of active-working play (35%) and neutral play (14%). When intervention occurred, Child 12 increased in progressive play (56%-86%) and reduced in active-working play (4%-22%), while she remained low levels of neutral play (8%-23%). At post-intervention, Child 12 demonstrated high levels progressive play (84%) and remained low levels of neutral play (16%), while she did not engage in any forms of active-working play.

Child 12's active-working play.

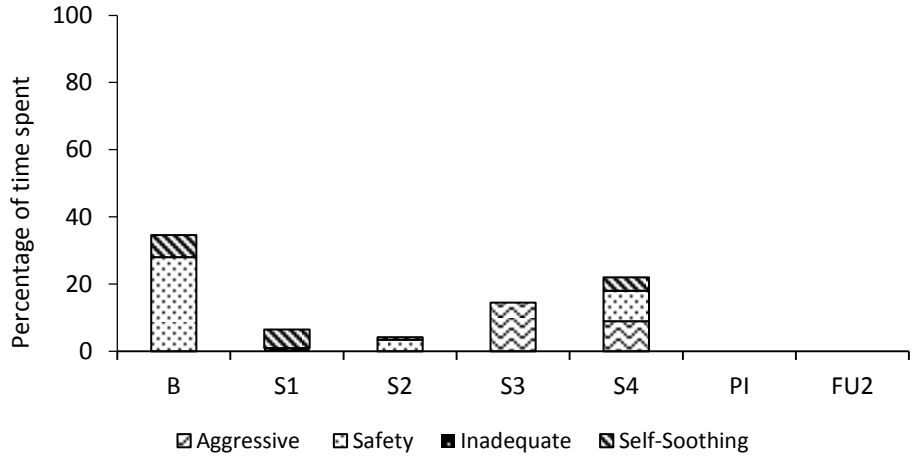


Figure 100. The percentage of time Child 12 spent in different types of active-working play during the 20-minute child-led play sessions across the experimental conditions. *Note.* B=Baseline; S=Session; PI=Post-intervention; FU2=Follow-up 2.

At baseline, Child 12 spent nearly 1/3 of the playtime in safety play (28%) and small amount of time in self-soothing play (7%). When intervention occurred, the overall time spent in active-working play was largely reduced, particularly during early intervention phase. While self-shooting play was demonstrated by Child 12 throughout the intervention phase, the time spent in it was gradually reduced. Similarly, Child 12 spent less time in safety play (0%-9%) than she had in baseline. She demonstrated inadequate play (1%) in Session 1 and some forms of aggressive play during late intervention (S3=15%; S4=9%). At post-intervention, Child 12 did not engage in any forms of active-working play.

Child 12's Progressive play.

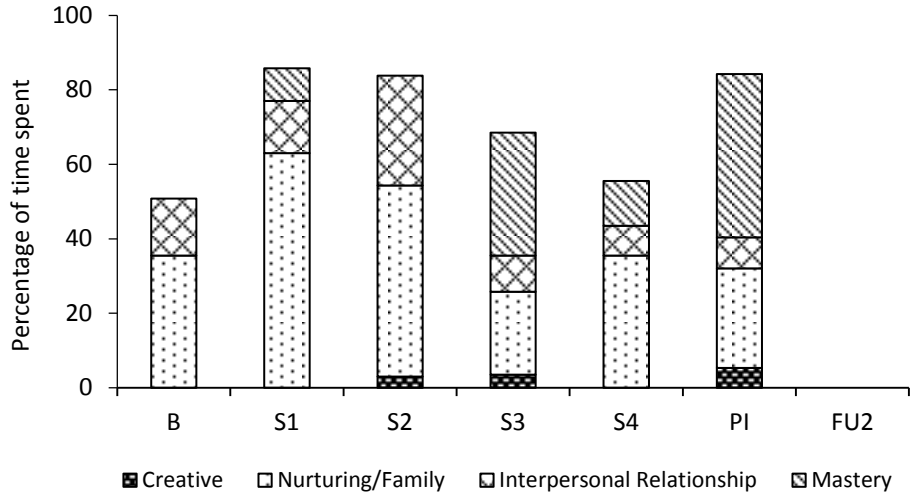


Figure 101. The percentages of time Child 12 spent in the different types of progressive play during the 20-minute child-led play sessions of across the experimental conditions. *Note*. B= baseline; S= session; PI= post-intervention; FU2=Follow-up 2.

At baseline, Child 12 demonstrated moderate levels of progressive play which was represented by some forms of nurturing and family play (36%) and interpersonal relationship play (15%). When intervention occurred, Child 12 increased in nurturing and family play (51%-63%), while she reduced in interpersonal relationship play (8%-10%). She also demonstrated some forms of mastery play in most sessions (S1=9%; S3=33%; S4=12%) and creative play during mid-intervention sessions (S2=3%; S3=4%). At post-intervention, Child 12 increased in mastery play (44%), while he reduced in nurturing and family (27%) and interpersonal relationship (8%) play.

Summary of child 12's play. In term of child play, when intervention occurred, Child 12 increased in progressive and neutral play while she decreased in active-working play.

Summary of Child Play

After implementation of intervention, most of the children increased in progressive play, while they decreased in neutral play and active-working play, in general during parent-child play observations.

Discussion of Child Play

The ninth research question of Study 2 pertains to "*Are there adaptive changes in the children's play during the video-recorded parent child play sessions over the intervention period?*" The video-observation data collected during the parent-child play sessions in Study 2 suggests no definite patterns in child play activities across children while the intervention was in progress. While a conclusive pattern of increment in progressive play did not emerge across all the children, some trends relative to the child self-concept were revealed. For example, five children who showed an overall increase in their progressive play reported either an increase in positive self-concept or a reduction in negative self-concept, while the child who reduced in progressive play decreased in self-reported positive self-concept. The remaining child whose progressive play fluctuated across the experimental period, with a subtle overall positive increment, reported a slight increase in his positive self-concept. The fact that most of the children who showed an overall positive increment in progressive play after the implementation of the intervention also reported an improvement in self-concept indicates a positive relationship between child progressive play and child self-concept.

These results are in line with Axline's (Axline, 1947) description of a well-adjusted individual as a person who "develops sufficient self-confidence to bring his self-concept out of the shadow land…and consciously and purposefully to direct his behaviour… to achieve his ultimate goal in life – complete self-realization" (pp. 13-14). Consistent with Axline's assumptions, the children who reported a positive self-concept after the intervention may have deliberately engaged in more progressive play, which includes nurturing, creative and

mastery types of play activities, as a sign of gains in self-confidence. In light of Study 2's findings and how Axline described a well-adjusted individual, an increase in child progressive play may suggest that the child is working on unveiling his or her positive self-concept, as an indicator of a child's progress following the intervention.

The Implication of the Adapted of BETPT to Research

The coding system of the adapted BETPT was used in Study 2 to capture the play behaviours or activities of each child during the weekly parent-child play sessions. Owing to the difference in the theoretical framework of BETPT, which is grounded in attachment and object-related theories, and child-centred play principles taught in adapted CPRT, the original BETPT has been modified in several aspects as described in table 29 (p.401). As a result, 12 play-theme were further divided into three categories, namely neutral play, active-working play and progressive play, to indicate the different stages in which a child was in the child-centred play sessions based on the play activities engaged in by the child, which were closely related to the process of personality change in person-centred therapy (e.g., L. Guerney, 2001; Ray, 2011; Rogers, 1961). While there was a considerable modification of the original BETPT, the modified BETPT would be a useful coding system to explore changes of child play activities following adapted CPRT.

This observational measure was developed for the purpose of Study 2 to (a) document different types of child play activities and then (b) group the child play activities into three different categories of play. The observational data are then used to reflect the different stages a child was working in, in regard to child-centred play therapy, across the period of study. A positive trend between an increased progressive play and improved positive self-concept was evident in most of the children in Study 2. While it highlighted that a specific category of play displayed by a child during child-centred play sessions conducted by the

parent might have contributed to an increased positive self-concept, the findings from this newly modified measure are indeed preliminary.

Limitation of the Adapted BETPT

The adapted BETPT was developed for the purpose of Study 2 to quantify different types of child play activities. However, the validity and reliability of the modified version of this coding system were not determined. Therefore, data revealed from the adapted BETPT is regarded as subjective, which imposes an explorative value to Study 2, thus the results are not evidentiary. Future studies are needed to examine the validity and reliability of this measure in its development to be a standardised observational measure.

Appendix L: Researcher's Training Certificates

Trauma-Informed Sandtray Therapy & Play Therapy

By

Prof. Dr. Linda E. Homeyer *(PhD, LPCS, RPTS)*

Attended by

VANESSA LOH YIN YIN

Total Contact Hours: 12 hours
August 8-9, 2015

The person identified above participated in this professional activity

Organized by Agape Counselling Centre Malaysia

Association for Play Therapy Continued Education Credit provided by Homeyer & Associates, APT Approved Provider 98-041

Mr. Wong Fook Hing
Chairman
Agape Counselling Centre Malaysia

Prof. Dr. Linda E. Homeyer
Professor of
Texas State University, USA

Play Therapy Supervision:
Theory & Process

By

Prof. Dr. Linda E. Homeyer *(PhD, LPCS, RPTS)*

Attended by

VANESSA LOH YIN YIN

Total Contact Hours: 12 hours
August 11-12, 2015

The person identified above participated in this professional activity

Organized by Agape Counselling Centre Malaysia

Association for Play Therapy Continued Education Credit provided by Homeyer & Associates, APT Approved Provider 98-041

Mr. Wong Fook Hing
Chairman
Agape Counselling Centre Malaysia

Prof. Dr. Linda E. Homeyer
Professor of
Texas State University, USA

Professional Supervision Training

By

Dr. Linda E. Homeyer

Attended by

Loh Yin Yin

Total Contact Hours: 12 hours
June 13-14, 2009

The person identified above participated in this training

organised by Play & Expressive Arts Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider
with Association for Play Therapy #98-041

Dr. Linda E. Homeyer
Professor
Texas State University,
San Marcos, USA

Mr. Andrew C. L. Ng
Director of Play & Expressive Arts
APT approved CE provider #08-218

Ms Lisa Sum
Director of Training
Agape Counselling Centre Malaysia
APT approved CE provider #08-238

Encountering Stress, Grief & Loss Creatively the Play and Sandtray Way

By

Dr. Linda E. Homeyer

Attended by

Loh Yin Yin

Total Contact Hours: 10 hours
June 7- 8, 2009

The person identified above participated in this workshop

organised by Play & Expressive Arts Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider
with Association for Play Therapy #98-041

Dr. Linda E. Homeyer
Professor of
Texas State University,
San Marcos, USA

Mr. Andrew C. L. Ng
Director of Play & Expressive Arts
APT approved CE provider #08-218

Ms Lisa Sum
Director of Training
Agape Counselling Centre Malaysia
APT approved CE provider #08-238

The Connecting Power of Filial Therapy

One-Day Child-Parent Relationship Training

By

Dr. Linda Homeyer

Attended by

Loh Yin Yin

Total Hours: 6 hours
6 May, 2007

The person identified above participated in this professional activity
organised by Play & Expressive Arts, Agape Counselling Centre Malaysia

Homeyer & Associates USA in an approved provider
with Association for Play Therapy #98-041

Mr. Andrew C.L. Ng
Director of
Play & Expressive Arts

Linda Homeyer PhD
Dr. Linda Homeyer
Professor of
Texas State University, USA

Ms Lisa Sum
Director of Counselling Department
Agape Counselling Centre Malaysia

Building Relationships Through Creative Art, Play, & Sandtray Therapy Workshop

2 - Day Professional Play Therapy Supervision

By

Linda E. Homeyer, PhD, LPC, NCC, RPT-S

attended by

LOH YIN YIN

Total Hours: 12 hours

10 & 11 July, 2006

The person identified above participated in the following professional activity jointly organised by Play & Expressive Arts, Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider with Association For Play Therapy # 98-041

Lisa Sum	Linda E Homeyer	
Mdm. Lisa Sum Head of Sandtray & Play Therapy Dept. Agape Counsselling Centre Malaysia	Dr. L. E. Homeyer Texas State University-San Marcos	Mr. Andrew C. L. Ng Director of Play & Expressive Arts

Building Relationships Through Creative Art, Play, & Sandtray Therapy Workshop

Advanced Sandtray Therapy

By

Linda E. Homeyer, PhD, LPC, NCC, RPT-S

attended by

LOH YIN YIN

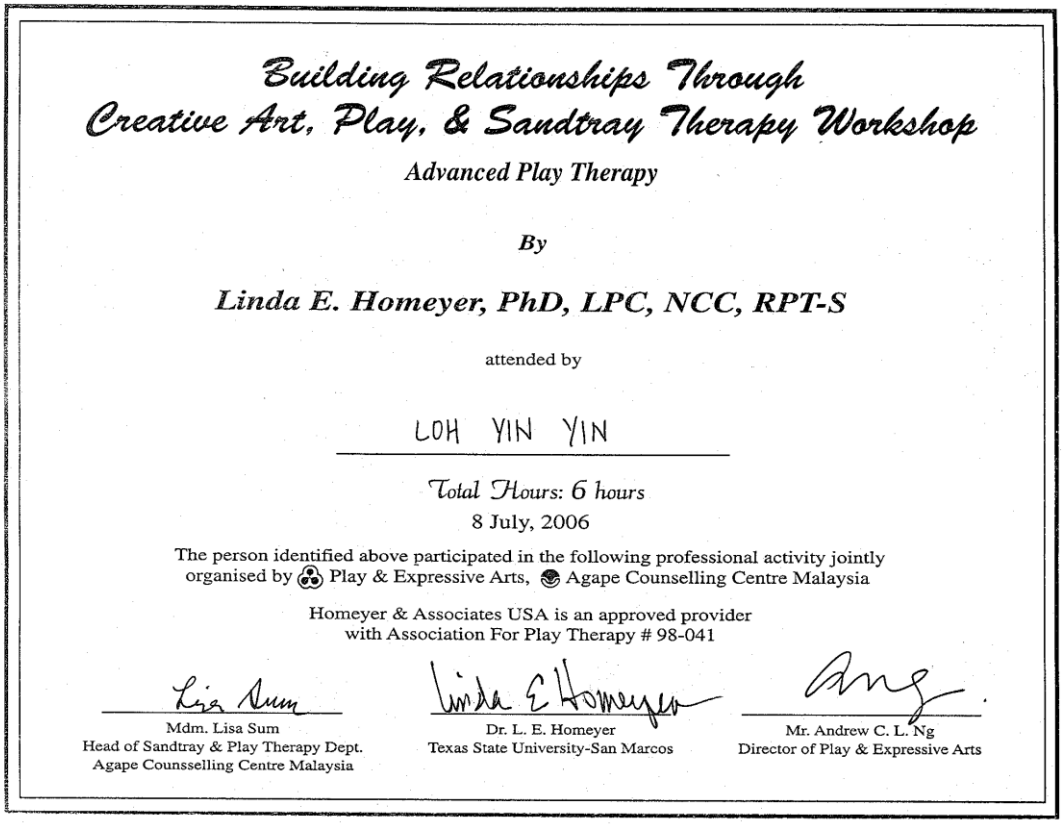
Total Hours: 6 hours

9 July, 2006

The person identified above participated in the following professional activity jointly organised by Play & Expressive Arts, Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider with Association For Play Therapy # 98-041

Mdm. Lisa Sum Head of Sandtray & Play Therapy Dept. Agape Counsselling Centre Malaysia	Dr. L. E. Homeyer Texas State University-San Marcos	Mr. Andrew C. L. Ng Director of Play & Expressive Arts



Building Relationships Through Creative Art, Play, & Sandtray Therapy Workshop

Advanced Play Therapy

By

Linda E. Homeyer, PhD, LPC, NCC, RPT-S

attended by

LOH YIN YIN

Total Hours: 6 hours

8 July, 2006

The person identified above participated in the following professional activity jointly organised by Play & Expressive Arts, Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider with Association For Play Therapy # 98-041

Mdm. Lisa Sum Head of Sandtray & Play Therapy Dept. Agape Counsselling Centre Malaysia	Dr. L. E. Homeyer Texas State University-San Marcos	Mr. Andrew C. L. Ng Director of Play & Expressive Arts

Building Relationships Through Creative Art, Play, & Sandtray Therapy Workshop

Art as Medicine - An Introduction to Art Therapy

By

Andrew C. L. Ng, *MCS, NZLID*

attended by

LOH YIN YIN

Total Hours: 6 *hours*

7 July, 2006

The person identified above participated in the following professional activity jointly organised by Play & Expressive Arts, Agape Counselling Centre Malaysia

Homeyer & Associates USA is an approved provider with Association For Play Therapy # 98-041

Mdm. Lisa Sum Head of Sandtray & Play Therapy Dept. Agape Counsselling Centre Malaysia	Dr. L. E. Homeyer Texas State University-San Marcos	Mr. Andrew C. L. Ng Director of Play & Expressive Arts

8 September 2011

Vanessa (Yin Yin) Loh
6/5 Haast Street
Linwood, Christchurch
Canterbury 8011
NEW ZEALAND

Dear Vanessa (Yin Yin)

I am pleased to inform you that your application to become an Accredited Standard Triple P Provider has been successful. You are now part of the growing network of Accredited Triple P Providers; congratulations on the hard work you have put in to meet the accreditation guidelines.

I enclose a certificate of accreditation issued by The University of Queensland, Brisbane Australia. Please keep this copy should you ever need to demonstrate your accreditation as a Standard Triple P Provider to clients.

Your achievement of accreditation with Triple P ensures that you will continue to be able to access the Triple P Provider Network. The Provider Network is designed to help you develop peer support networks, access tips and techniques in delivering Triple P, and keep you up to date with the latest news, resources and research regarding Triple P. It also provides you with access to the Client Scoring Application, a feature that allows you to score most Triple P standard questionnaires and provides you with a family's profile and assessment summary report.

The website for the Triple P Provider Network is www.triplep.org. If you haven't already done so, please create a new account on the Provider Network with the registration code below. This code will give you access to the resources and Clinical Tools associated with the course in which you have been accredited.

Level 4 Standard Triple P Provider Training Course
Registration Code: 113459

If you are an existing account holder, to extend your access please go to 'My Account' and click on the 'edit' tab. Enter the registration code in the 'registration codes' text field and click the submit button at the bottom of the page.

If you would like further information about training programs or Triple P resource material please contact us at training@triplep.net.

Yours sincerely

Alan Ralph PhD MAPS MBPS
Head of Training

Triple P International Pty Ltd ABN 17 079 825 817

11 Market Street North, Indooroopilly Qld 4068 PO Box 1300 Milton Qld 4064 Australia **tel:** +61 7 3236 1212 **fax:** +61 7 3878 5510 **web:** www.triplep.net

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Positive Parenting Program®
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This is to certify that

Vanessa Loh Yin Yin

is an accredited provider of

LEVEL 4
STANDARD TRIPLE P

8 September 2011

Matthew R. Sanders PhD
Professor and Director of the
Parenting and Family Support Centre
Founder of Triple P-Positive Parenting Program

RECOGNITION OF NON-AWARD PROGRAM

Completion of this program does not provide credit points towards the official academic courses and awards of the University

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AUSTRALIA